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May 3, 2012

NOTICE OF INITIATION OF 30-DAY PUBLIC REVIEW AND COMMENT PERIOD
RE: MHSA FISCAL YEAR 2012/2013 ANNUAL UPDATE WITH ENHANCEMENT #9

Dear Community Members and Stakeholders:

San Diego County is holding a 30-day public review and comment period for the Mental Health Services Act (MHSA) Fiscal Year 2012/2013 Annual Update with Enhancement #9. This review period begins May 3, 2012 and ends June 4, 2012. A public hearing will be held at our Mental Health Board on Thursday, June 7, 2012, at 4:00 PM.

The Annual Update outlines our current Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Workforce Education and Training (WET), Innovation (INN) and Capital Facilities/Technological Needs (CF/TN) plans. Enhancements to work plans are included that increase the capacity of a number of our programs.

Please review our MHSA Annual Update with Enhancement #9 and send your comments, suggestions, and/or questions to our MHSA line below.

Mental Health Services Act Comment/Question Line:
Phone: (619) 584-5063
Toll-Free: (888) 977-6763
Email: MHSProp63.HHSA@sdcounty.ca.gov

Submitted by,

ALFREDO AGUIRRE, LCSW
Deputy Director
Mental Health Services

KAREN VENTIMIGLIA
MHSA Coordinator
Mental Health Services

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COUNTY OF SAN DIEGO MHSA ANNUAL UPDATE: FISCAL YEAR 2012/13

7/1/2012

MHSA: Making a Difference

This report is written by the County of San Diego Behavioral Health Services Department for community stakeholders. It describes the Mental Health Services Act (MHSA) funded programs, provides an implementation progress report for Fiscal Year 2010/11 and an expenditure plan for Fiscal Year 2012/13.

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MHSA Annual Update: FY 2012/13

MHSA: MAKING A DIFFERENCE

A LETTER FROM THE MENTAL HEALTH DIRECTOR

San Diego County, Health and Human Services Agency, Mental Health Services' vision is to assure healthy communities by providing an array of state-of-the-art mental health services to children, youth, families, adults and older adults. The Mental Health Services Act (MHSA) has provided a unique opportunity to further transform public mental health services in San Diego. San Diego's mental health system transformation has evolved in the past ten years with broad participation of client, family/youth, advocates, public system partners, private providers and the community at large.

Through MHSA funding, underserved populations have improved access to care, effective services that improve the quality of life for clients and the use of less restrictive care for children and youth, adults and older adults. In addition, our prevention and education efforts focus on reducing the stigma of mental illness and increasing access to services. We are committed to significantly increase client, family and youth participation at the practice, program and policy levels, and in client-operated services.

San Diego Mental Health Services anchors its delivery in the practice of system of care values and principles, applying a bio-psychosocial rehabilitation and recovery model for services provided to adults older adult that is consistent with the California Mental Health Directors Association (CMHDA), Adult and Older Adult systems of care frameworks. For Children's Mental Health Services, the system of care values is consistent with wraparound philosophy and guiding principles.

This is the first year that the County of San Diego has the flexibility to provide a report written for stakeholders, rather than for the California State offices. The flexibility was provided through AB-100, legislation which not only redirected MHSA funds that were at the State, but also allowed for more decisions to be made at the County level.

I am pleased to present this draft report to you. I welcome and look forward to your comments and ideas for improving this report.

Sincerely,

ALFREDO AGUIRRE, LCSW
Director
Mental Health Services
County of San Diego

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INTRODUCTION

In July 2010, the San Diego County Board of Supervisors unanimously adopted a visionary 10-year plan, *LIVE WELL, SAN DIEGO!,* to improve the health and well being of our community. Supporting the County's vision, the plan strategically outlines goals and actions to provide innovative and integrated service delivery to the residents of San Diego so they can enjoy lives that are **Healthy**, **Safe** and **Thriving**. Each of these three strategic agendas has a distinct yet interwoven collection of measurable activities that are categorized within four major pillars:

- Building a Better System
- Supporting Positive Choices
- Pursuing Policy Changes for a Healthy Environment
- Changing the Culture From Within

The Mental Health Service Act (MHSA) funded programs support the Health Strategy Agenda, known as "Building Better Health," which focuses on both tangible and perceived health issues. MHSA implementation in San Diego County demonstrates the County's commitment to collaborating with community partners and businesses, aligning internal services to ensure healthy, safe and thriving communities for all residents, and puts *LIVE WELL, SAN DIEGO!* into action.

While adhering to the principles of MHSA and the guiding principles of the Adult/Older Adult and Children's Systems of Care, the MHSA, as implemented in San Diego County, addresses the four major pillars of *LIVE WELL, SAN DIEGO!*:

Building a Better Service Delivery System is essential to a healthier community. Integration of physical health, behavioral health and social services is a key component to building a service delivery system that improves quality of care and is responsive to the needs of customers. Access to the right care at the right time is critical to achieving and maintaining the health of an individual. A few examples illustrating strides made towards building a better service delivery system through MHSA are:

- Integration of physical and behavioral health care;
- Improved identification and availability of suicide prevention and mental health resources;
- Reducing the stigma associated with mental illness and suicide so that individuals are comfortable reaching out, getting help early and communities are understanding that "home is where recovery begins" for someone with a severe mental illness;
- Improved coordination of services for high-risk populations.

Supporting Positive Choices is about enabling our community to make the healthy choice, the right choice. Because the healthy choice is not always the easy choice, it is critical to remove barriers to making the right choice. A couple of examples of how MHSA funded programs illustrate this follow.

- Clubhouses are providing healthy cooking classes and information and encouraging smoking cessation programs for clients;
- County of San Diego Regional Community Health Promotion and Aging Program Specialists broaden the reach of education and training by incorporating physical health and mental health in their messaging;
- *It's Up to Us* Stigma and Discrimination Reduction and Suicide Prevention Media Campaign is providing wellness tips on their newsletters.

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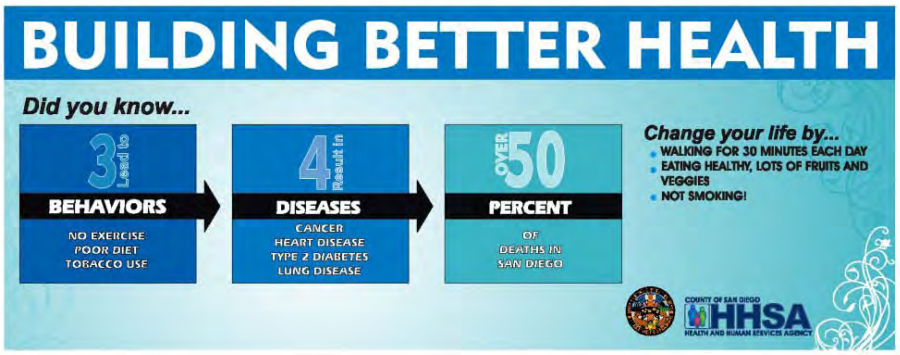
Pursuing Policy and Environmental Changes is an effort to incorporate health in all policies. By looking at areas such as transportation and planning through a health lens, we are able to create sustainable change in our region that supports healthy living. A few examples that illustrate this:

- Expand basic prevention education and training to the population at large so they can recognize the signs and symptoms of suicide risk as commonly as they can for other health risks like a heart attack or a stroke.
- Expand the definition of "providers" to include those outside of the behavioral health realm, and give them adequate training, education and support.
- Plan for a healthy environment in the capital facilities projects that will house programs.

Improving the Culture from Within County Government is about the internal County Team. A healthier and more knowledgeable County workforce is a more productive workforce, and in turn, enables employees to better serve all those who use County services. Behavioral Health staff participates in:

- A "virtual" walk across the country through a walking challenge;
- Suicide prevention walks, walks for mental health awareness and recovery activities;
- The development of an internal training for HHSA employees on stigma and discrimination that is associated with mental illness.



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WHAT IS MHSA?

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides the first opportunity in many years for the California Department of Mental Health (DMH) to make available increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families. MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. MHSA imposes a 1% income tax on personal income in excess of $1 million. MHSA has five program components. The implementation of these components will be discussed in detail within this report.

Community Services and Supports (CSS)

New MHSA programs and strategies are implemented through the CSS component. These programs and strategies are improving access to underserved populations, bringing recovery approaches to current systems, and providing "whatever it takes" services to those most in need. These programs offer integrated, recovery-oriented mental health treatment, case management and linkage to essential services, housing and vocational support; and self-help.

Prevention and Early Intervention (PEI)

Prevention programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue. To facilitate accessing supports at the earliest possible signs of mental health problems and concerns, PEI builds capacity for providing mental health early intervention services at sites where people go for other routine activities (e.g., health providers, education facilities, community organizations). Mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness.

Innovation

Innovations are defined as novel, creative and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative of unserved and underserved individuals. The Innovation Component allows counties the opportunity to "tryout" new approaches that can inform current and future mental health practices/approaches.

Workforce Education and Training (WET)

The overall mission of Workforce Education and Training is to develop and maintain a sufficient public mental health workforce that is capable of providing client and family driven, culturally competent services that promote wellness, recovery and resiliency. WET programs develop training curricula, incorporate cultural competency in all training and education programs, increase mental health career development opportunities, expand postsecondary education capacity, expand loan repayment scholarship programs, create stipend programs, promote distance learning techniques,

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promote employment of clients and family members in Mental Health system, and promote meaningful inclusion of client and family members in all training and education programs.

Capital Facilities and Technological Needs

Capital Facilities supports the goals and provision of MHSA services through the development of a variety of community-based facilities that support integrated service experiences. Funds may also be used to support an increase in peer-support and consumer-run facilities and the development of community-based, less restrictive settings that will reduce the need for incarceration or institutionalization.

Technological Needs projects demonstrate the ability to serve and support the MHSA objectives through cost effective and efficient improvements to data processing and communications. The goals of these technology enhancements are to: 1) increase client and family empowerment and engagement by providing the tools for secure client and family access to health information through a wide variety of settings and 2) modernize and transform clinical and administrative information systems to ensure quality of care, parity, efficiency and cost effectiveness.

The MHSA also supports two additional elements as follows:

Community Program Planning (CPP)

The purpose of Community Program Planning is to provide a structure and process that the County uses, in partnership with their stakeholders, in determining how best to utilize funds.

Housing Program

The MHSA Housing Program finances capital costs associated with development, acquisition, construction and/or rehabilitation of permanent supportive housing for individuals with mental illness and their families, especially including homeless individuals with mental illness and their families. The MHSA Housing Program embodies both the individual and system transformational goals of the MHSA through a unique collaboration among government agencies at the local and State level.

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COMMUNITY STAKEHOLDER PROCESS

The County of San Diego integrated information from the extensive Community Program Planning process, data from the MHSA Gap Analysis, and community input from our stakeholder-led councils (Children's System of Care Council, Adult System of Care Council, Older Adult System of Care Council, Housing Council and Mental Health Board) in the development of our Fiscal Year (FY) 2012/13 Annual Update.

The stakeholder-led councils provide a forum for both Council representatives and the public to stay informed and involved in the planning and implementation of MHSA programs. The members of these councils received draft materials and presentations from the County's MHSA Coordinator on the impact of Assembly Bill 100 on San Diego's community planning and approval process and the County's proposal for the Annual Update. Community input from these councils was collected during the FY 2012/13 planning phase and considered during development of the Annual Update. Council members also shared MHSA information with their constituents and other groups involved in mental health services and issues.

The County's Behavioral Health Services Division is comprised of Mental Health Services and Alcohol and Drug Services (ADS) working together to meet the needs of the community. Throughout MHSA planning activities, ADS providers offered essential input on the needs for specialized mental health assistance for clients currently receiving treatment in ADS-contracted programs. Additional input was received during numerous community forums, as well as through the ADS Providers Association and monthly ADS Provider meetings.

The Mental Health Board is comprised of consumers, family members, and individuals from the mental health field representing each of the five County Supervisor districts.

Membership within the Children's, Adult, and Older Adult System of Care Councils includes consumers and family members, as well as other key stakeholders in the community such as providers, program managers, representatives of consumer and family organizations, advocacy groups, education representatives, and County partners.

In addition, the MHSA Planning Team utilizes an extensive list of interested parties (e.g., stakeholders, providers, consumers, family members) to send updates and communications about planning meetings, documents, and proposed updates to the MHSA Plan. Annual Update information and input requests were emailed to other stakeholder distribution lists, including the Mental Health Coalition and Contractor's Association.

The draft Annual Update will be posted on the County's Network of Care website. Community and stakeholder input was also solicited and received via telephone (local and toll-free lines), internet, and email using the County's MHSA Proposition 63 comment/question line.

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FISCAL YEAR 2010-2011 IMPLEMENTATION PROGRESS

San Diego County Demographics – 2010 Census

The County of San Diego Health and Human Services Agency's *Live Well, San Diego*! Annual Report for Fiscal Year 2010/11 states that San Diego County covers 4,261 square miles and is nearly the size of the state of Connecticut, with an elevation that goes from sea level to 6,500 feet. The county includes beaches, valleys, deserts, and mountains. With more than 3 million residents, the county is comprised of 18 cities and 17 unincorporated communities. It borders Mexico to the south, Orange and Riverside Counties to the north, the agricultural communities of Imperial County to the east, and the Pacific Ocean to the west. Its population is ethnically and racially diverse. In fact, one-third or nearly 1 million county residents speak a language other than English at home.

Hispanic	991,348	32%
Non-Hispanic	2,103,965	68%
- White	1,500,047	48%
- Black	146,600	5%
- American Indian	14,098	0%
- Asian	328,058	11%
- Hawaiian & Pacific Islander	13,504	0%
- Other	6,715	0%
- Two or More Races	94,943	3%
All Ethnic Groups	**3,095,313**	**100%**

Addressing Disparities

San Diego County Mental Health Services continues to develop and monitor the provision of linguistically and culturally appropriate services for the diverse populations of our County, focusing special attention on unserved/underserved communities. Below are highlights that represent some of the contributions our programs have made to address ethnic and racial service disparities and system transformation.

Community Services and Supports (CSS)

The total number of individuals served by the Children's system of care programs has increased by 5% from Fiscal Year (FY) 2006/07 (17,253) to FY 2010/11 (18,100); 2.5% of that increase came between

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FY 2009/10 and FY 2010/11. The majority of MHSA funding continues to be used for expanded efforts by existing services to reach out to underserved, including, specific ethnic groups, children without insurance, and children already involved with other public services.

Over 30% of MHSA CSS funding has been used for more comprehensive services for under-served children involved with Child Welfare Services and the Court system. In the children's mental health population in FY 2010/11, 19% of the clients were involved with Child Welfare Services and 17% received Probation services. School based service expansion continues to constitute approximately 25% of CSS funding with targeted outreach efforts to under-served special language groups and to uninsured children. New Prevention and Early Intervention (PEI) services have been tailored for the comparatively small population of 0-5 year olds with mental health concerns, with the intent of intervening to divert these youngsters from needing future mental services. Since youth age out of the Children's system, the capacity of the system to expand may be more limited than the adult system.

There was a 6% increase in the number of Hispanic children receiving services in FY 2010/11 (9,506) versus FY 2009/10 and a 2% decrease in the number of White children being served. There was also a slight increase in the number of African American and Asian/Pacific Islander children served. The number of Native American children served, however, decreased from 125 served in FY 2009/10 to 109 served in FY 2010/11. Overall, the increase in the numbers of minority populations served is an indicator that outreach efforts to the underserved populations are meeting with a degree of success, although expanding avenues of outreach is necessary to bring these numbers closer to the percentages of minorities in the children's population as a whole.

Between FY 2006/07 and FY 2008/09, the growth rate for the adult mental health population had been spurred by the creation of CSS programs, specifically for transition age youth (TAY) and for older adults. Prior to the implementation of MHSA, these age groups had been only peripherally involved in adult programs because of a lack of available funding to tailor programming for their special needs. The number of TAY clients served has increased 22% from FY 2006/07 to FY 2010/11, through MHSA targeted clubhouse, Full Service Partnerships (FSP), TAY counselors at community clinics, alcohol and drug combined services, etc. In FY 2010/11, San Diego County delivered mental health services to 6,198 TAY clients; 15% of the total 41,222 clients served. Efforts to reach out to Hispanic TAY have been met with some success. The TAY clients served in FY 2010/11 were 42% White and 31% Hispanic, whereas the total adult client population was 50% White and 21% Hispanic.

The number of older adult clients served increased 38% from FY 2006/07 to FY 2010/11, primarily as a result of MHSA targeted programming such as mobile outreach, FSP programming, use of promotoras, etc. For older adults, San Diego County provided mental health services to 4,594 individuals age 60 years and older; 11% of the total clients served. The older adult clients were more likely to be White (58%) compared to the overall client population (50%) and less likely to be Hispanic (13% compared to 21% in the total client population.) Outreach efforts to Asian/Pacific Islander appear to have met with some success - 8% of the Older Adults are in this ethnic group versus 6% in the total client population. The PEI funded *It's Up to Us* anti-stigma campaign with its efforts aimed at specific age groups is expected to help people of all ages become less reluctant to seek services.

The total number of clients served (41,222) by adult and older adult specialty mental health programs decreased by 5% from the total clients served in FY 2009/10 when 43,383 clients were served. Two

factors are believed to have contributed to this decrease. The PEI programs which began in FY 2010/11 may have provided a successful intervention for some participants, encouraging them to seek mental health assistance before needing to seek higher intensity services from the County. Secondly, in an effort to better integrate mental and physical health care, clients who were felt to be stable on their medications were encouraged to transfer over to receiving services from their local Federally Qualified Health Center.

The client gender in FY 2010/11 was 48% female and 52% male. The clients were slightly more likely to be male compared to the overall San Diego County population. The proportion of clients served in each age group has remained stable over the past four fiscal years. In FY 2010/11, 15% of clients were age 18-24 (transition age youth-TAY), 74% age 25-59 and 11% were age 60 and older. The distribution of client ethnicity and race remained essentially stable from FY 2006/07 to FY 2010/11.

The percentage of clients with English as their preferred language increased to 82% of the mental health adult population from 79% in FY 2009/10. The percentage of clients with Spanish and Arabic language needs remained constant at 7% and 1%, respectively. The percentage of clients with Vietnamese or another Asian language needs rose approximately 1% between FY 2009/10 and FY 2010/11. It should be noted that children who are receiving services may be comfortable with English as their preferred language, but their parents (who are not clients) may still have a need for non-English services.

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Community Services and Supports

Providing integrated mental health and other support services to those whose needs are not currently met through other funding sources

Implemented through the Community Services and Supports (CSS) component are the first generation of MHSA programs and strategies which are improving access to underserved populations, bringing recovery approaches to current systems, and providing "whatever it takes" services to those most in need. These programs offer integrated, recovery-oriented mental health treatment; case management and linkage to essential services; housing and vocational support; and self-help.

CSS contains four service categories:

- Full Service Partnership (FSP)
- Outreach and Engagement (OE)
- General System Development (SD)
- MHSA Housing Program

The following contains a brief description of each of the four service categories as well as program highlights from FY 2010/11. For more demographic information on Full Service Partnership programs, please refer to Appendix A.

Full Service Partnerships

Full Service Partnerships (FSP) provide all of the mental health services and supports a person wants and needs to reach his or her goal and treatment plan. FSP services comprehensively address client and family needs and "do whatever it takes" to meet those needs, including intensive services and supports and strong connections to community resources with a focus on resilience and recovery.

FSP FOR CHILDREN AND YOUTH (CY-FSP)

These programs serve children, youth, and transition age youth (TAY) up to age 21, who have a diagnosis of serious emotional disturbance or serious mental illness and their families. Special targeted populations include indigent/unserved Latinos and Asian/Pacific Islanders, homeless or runaway children and youth, and children and youth who are Medi-Cal eligible, transitioning home or to a home-like setting from residential-based services, and at risk of returning to a higher level of care.

These programs provide an array of full service partnership services including assessment, case management, intensive mental health services and supports, psychiatric services, referrals, linkage with community organizations and co-occurring services. Services are strength-based, family-oriented, focus on resilience and recovery, and encompass mental health education, outreach, and a range of mental health services as required by the needs of the target populations. These programs offer four targeted approaches.

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- Cultural/Language Specific Services is based on principles of community involvement, cultural and linguistic competence, and outreach to underserved Latino and API children and youth and their families.
- Homeless and Runaway Services focuses on conducting outreach and engagement to homeless youth, making connections with homeless-specific community organizations, and linking clients to existing homeless youth outreach workers and community resources.
- Child Welfare Services (CWS) and Probation Department Services provide highly individualized services to maximize the capacity of the family to meet the child's needs, thereby reducing the child's level of care from a group home placement to a home or home-like setting. In addition, Early Periodic Screening Diagnosis and Treatment (EPSDT) services provide medication support for children and adolescents who are full scope Medi-Cal beneficiaries.
- Clinic-Based Services are provided in six locations throughout the County to a diverse range of children, youth, and families. These services are designed to promote access to medical, social, rehabilitative, or other needed community services and supports. Case managers/rehabilitation workers provide mental health rehabilitative services, home visits, and assistance to parents to manage treatment appointments and service plans. Many case managers/rehabilitation workers have bilingual language capacity to serve parents who are often monolingual.

These programs further the goals of the MHSA by providing culturally competent, wraparound services for identified unserved and underserved populations with a focus on family inclusion. Services are designed to address access disparities and reduce stigma associated with mental health services and treatment. These programs also strive to reduce institutionalization and promote integrated service experiences for clients and families

FY 2010/11 Highlights

- The CARE program provided services to 156 unduplicated clients surpassing the 91 unduplicated client targets for the FY with a family participation rate of 98%. The program attended fairs and events within the Central and North Central Regions of San Diego with a strong emphasis on Latino and Asian/Pacific Islander (API) events which resulted in successful contacts and lasting relationships with pediatricians, general practitioners, dentists and other medical professionals who primarily serve the API and Latino communities allowing the program to find medical homes for everyone of their clients and families if they have none during intake. The program conducted 1,757 extensive outreach and education activities to the community which resulted to the increase in API enrollment to the program. A CARE Clinician provided an interview on a Vietnamese radio show, TNT Radio Network, which was aired on 09/14/10. He discussed CARE services, cost of service, parenting difficulty for Vietnamese speaking parents, acculturation, depression in children and services available to the Vietnamese community in San Diego County.
- Harmonium Family/Youth Partner Program supported Building Better Health, the County Strategic Health Plan, by encouraging family participation in community events that focus on enhancing mental health services of their children like produce market activities, healthy cooking events where instructions on preparing healthy meals and lifestyles are provided. The program conducted 619 outreach services that involved attending meetings and forums to gather and document community input regarding the services the target community want.

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FSP FOR AGES 18 THROUGH 65+ (TAOA-FSP)

These programs, which are made up of several services of varying focus, serve unserved or underserved transition age youth (TAY, age 16 to 24), adults (age 25-59), and older adults (age 60 and above) who have a diagnosis of serious mental illness and may have a co-occurring substance use disorder. These individuals may be homeless or at risk of becoming homeless, living in a locked long-term care or skilled nursing facility, high utilizers of acute inpatient care and medical services, emergency departments, shelters and psychiatric hospital and those under the care of institutions or at the risk of institutionalization or have active or recent criminal justice involvement. These programs also reach out and engage women, African-Americans, Latinos, and Asian/Pacific Islanders with serious mental illness.

These programs provide a variety of integrated services which may include supported housing (temporary, transitional, permanent), with a focus of age and developmentally appropriate outreach and engagement, 24/7 intensive case management, wraparound services, community-based outpatient mental health services, rehabilitation and recovery services, supported housing, supported employment and education, dual diagnosis services, peer support services, diversion and reentry services, and other housing options. Some services utilize the Assertive Community Treatment (ACT) model, which is an evidence-based practice that has repeatedly demonstrated effectiveness for people who have serious mental illness who have not been adequately served by the usual service system. All services are delivered with cultural competence and are linguistically appropriate. Programs include the following unique components and services:

- Housing Trust Fund, based on the recommendation of the stakeholders in San Diego, sets aside unspent one-time and ongoing housing funds that are used to increase permanent supportive housing opportunities for transition age youth, adults, and older adults in the CSS FSP integrated homeless programs. These funds are set-aside in this trust fund to leverage the development of affordable project-based permanent supportive housing for these low income clients.
- Mental Health Calendar provides mental health services for individuals with SMI who have been found guilty of a non-violent crime (either misdemeanor or felony) and are awaiting sentencing. Most individuals are repeat offenders who may have received mental health services while incarcerated or in the community and are referred for services via the justice system. The program is delivered by a specialized, multi-agency Mental Health Calendar that includes Superior Court, District Attorney, Sheriff, Public Defender, Probation, and Behavioral Health Services (Mental Health and Alcohol and Drug Services).
- Residential Integrated Treatment provides 24-hour rehabilitation and recovery services, psycho-education, care coordination, supported employment and education, and peer support services. Physical health screening, consultation, linkage, referral and follow up with primary care provider. This service develops community collaborations to provide employment, housing, and other supports for clients transitioning to independent living.
- Case Management is based on the Strength-Based Care Management model that provides treatment, education, and skill building activities for older adults. Outreach, screening/assessment, social skills training, co-occurring services, assistance with activities of daily living, brokerage, and support services are offered.
- Transition Team Services works to reduce psychiatric hospitalization and improve community support through short-term intensive case management services to individuals who have Medi-Cal,

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no current Care Coordinator, and are hospitalized at one of San Diego's Medi-Cal psychiatric hospitals.

- High Utilizers of emergency departments, shelters, psychiatric hospitals and those who have had legal and/or justice system involvement are provided intensive services.

These programs were expanded to provide a range of Case Management and peer-delivered services to persons 18 to 59 of age who are or have been living in institutional care facilities.

These programs advance the MHSA goals to reduce incarceration and institutionalization, to increase meaningful use of time and capabilities, to reduce homelessness and to provide timely access to needed help for unserved and underserved individuals by providing intensive, wraparound services. In addition, these programs advance rehabilitation and recovery practices by assisting clients in their personal recovery via a wellness and resilience focus, as well as in seeking and sustaining employment and educational goals.

FY 2010/11 Highlights

- Intensive Mobile Assertive Community Treatment was named Mental Health Program of the Year in 2011 from HHSA. IMPACT provides Assertive Community Treatment (ACT) services to 224 Central and North Central Region adults with severe mental illness who have been homeless and who often have co-occurring disorders. Clients at IMPACT have a range of high needs and have demonstrated poor engagement and outcomes in the past. All of IMPACT's ACT team members work collaboratively to "do whatever it takes," relying on eight complementary evidence-based and best-practice models, including Wellness and Recovery Action Planning, full fidelity ACT services, a Housing First approach, Motivational Interviewing, and others. Once clients are engaged, housed, and psychiatrically and medically stabilized, a vocational specialist is available to work with them. In FY 10-11, an innovative partnership established between IMPACT and "Mind Treasures," a non-profit organization that creatively supports financial literacy. Data from the state's Data Collection and Reporting System as of June 15, 2011, showed that no IMPACT clients were homeless (although less than 10 clients are in jail, hospital, or an emergency shelter situation), 14% of their clients have some involvement in volunteer or paid employment (compared to 1% upon admission), and 99% of their clients have an identified primary care physician.
- Starting Point, which provides 24/7 intensive wrap around services to help TAY in recovery from co-occurring mental health and substance use issues live independently, served 49 unduplicated clients. The program focuses on encouraging each client's recovery and pursuit of a full, productive life by working with the whole person, rather than only focusing on alleviating symptoms. Taking into account this holistic view, treatment at Starting Point addresses the six dimensions of health - physical, social, mental, emotional, spiritual and environmental. The program provided clients with comprehensive, intensive dual diagnosis-enhanced services within a structured, residential treatment program. Clients are supported within the community to accomplish many tasks including visits to the County Recorder, Social Security Administration, and Department of Motor Vehicles offices to get needed documentation. The clients were also provided transportation and financial support to acquire their GED or High School diplomas through local night school venues. Starting Point provided access to the National Alliance on Mental Illness (NAMI) 12-week Peer-to-Peer course for individuals desiring to become Peer Facilitators. Clients were supported in volunteer work in the community at Friends of Cats animal shelter and Father Joe's. The program empowered family members by incorporating a Family

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Resource hour into their monthly "Family Night". The Family Resource hour drew upwards of 50 participants in one evening. In addition, the program provided residents with culturally enriching activities including but not limited to a Cinco de Mayo luncheon and a Memorial Day BBQ. Residents also participated in community outreach at events such as the County of San Diego's May is Mental Health month Drumming Out Stigma event and public activities such as beach cleanups and the Save a Life 5K in Balboa Park. Throughout the fiscal year, the program worked to revise their program rules to adopt a more structured philosophy to better serve their intended population. Ample time was spent in training staff and working with clients about the changes. The result proved to be an increased ability for participant's to maximize the benefits of the program.

- Catalyst provided Assertive Community Treatment (ACT) to 257 unduplicated TAY clients. Catalyst ACT services are recovery-oriented and strengths-based and include: mental health services, psychiatric services, nursing services, case management, benefits advocacy and management, supportive housing services and rental subsidy assistance, employment and education assistance, peer mentorship and counseling, and co-occurring disorders treatment. The program conducted ongoing communication and outreach with other community providers and partners such as Child Welfare Services, local crisis stabilization programs and psychiatric hospitals. One of the challenges that Catalyst staff continuously dealt with during FY 2010-11 was being over capacity. They received a range of two to seven referrals per week, as well as one to two high priority referrals per week. To mitigate this issue, the program consistently participated in meetings with other ACT team programs, case management programs, and County personnel to address the capacity and referral prioritization issues.
- Behavioral Health Services is a partner in United Way's Project 25 program, a 3-year pilot program that provides permanent housing, supportive services and a comprehensive discharge program to at least 25 of San Diego's chronically homeless and some of the most frequent users of public resources. In spring 2011, the Gateway, a Full Service Partnership program, was enhanced to provide services to 20 persons. The following criteria were used to identify qualifying individuals: frequent users of public resources including legal, medical, and emergency services, have a serious mental illness, and who may be homeless. The contractor provided services that included outreach and engagement, mental health assessment and treatment, rehabilitation and recovery services, case management, and housing support. They worked in close partnership with St. Vincent de Paul Village's Project 25 program, which served as the gatekeeper and identified which potential clients were eligible, to identify/screen/assess clients, coordinate services, and ensure that clients receive services.
- Following San Diego Registry Week in September 2010, which documented at-risk homeless individuals in central San Diego, Downtown Impact and Center Star, two Full Service Partnerships were expanded to provide services to 50 homeless individuals. These individuals were identified through the Vulnerability Index and often had tri-morbid conditions including physical health conditions, serious mental illness, and substance abuse. The FSPs provided services that include outreach and engagement, mental health assessment and treatment, rehabilitation and recovery services, case management, and housing support.

Outreach & Engagement

Outreach and Engagement (OE) reaches out to people who may need services but are not getting them.

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OUTREACH & ENGAGEMENT FOR ALL AGE GROUPS (ALL-OE)

This program serves seriously emotionally disturbed children (age 0-17) and seriously mentally ill transition age youth (age 18-24), adults (age 18-59), and older adults (age 60 and above) who are deaf or hard of hearing or victims of trauma and torture. This program also serves uninsured individuals receiving physical health care at community clinics who are not currently receiving mental health services. Special focus is placed on individuals identified as unserved or underserved by San Diego County's Gap Analysis, which includes Native Americans, Latinos, Asians/Pacific Islanders, and African Americans.

This program offers a variety of outreach and engagement, and outpatient mental health services, including care coordination, linkage, and individualized/family-driven services and supports. Clients are provided with necessary linkages to appropriate agencies for psychotropic medication management if necessary, as well as services for co-occurring substance abuse disorders. Targeted services include:

- Services for the Deaf and Hard of Hearing reaches out to, and offers specialized counseling for individuals with hearing impairments. The program provides interventions to assist clients and families to achieve a more adaptive level of functioning. Services are provided in Communication Accessible languages including, but not limited to, American Sign Language.
- Services for Victims of Trauma and Torture reaches out, engages with, and provides specialized interventions for these individuals, as well as trainings for other providers on working more competently and effectively with victims of trauma and torture.
- Mental Health Services in Community Clinics provides treatment services to uninsured individuals through a master agreement with the Council of Community Clinics for management and authorization of care and general system management. The Council of Community Clinics represents a consortium of community clinics and Indian Health Services providers in San Diego County. The goal of this program is to integrate care between the primary care provider and the mental health provider within the same clinic structure.

These services advance MHSA goals by increasing access to services for unserved and underserved individuals through an integrated system of collaboration with mental health and community providers. These services reduce mental disability and restore functioning for individuals through education, targeted services, and support for enhanced self-sufficiency. In addition, this program provides a range of rehabilitation interventions to assist persons with serious mental illness achieve a desired quality of life consistent with a bio-psychosocial approach.

FY 2010/11 Highlights

- Deaf Community Services expanded to provide alcohol and drug counseling with the addition of an experienced and certified Alcohol and Drug counselor who is American Sign Language-fluent.
- Survivors of Torture International (SOTI) served 101 unduplicated clients. Specific outreach and education activities included presentations to stakeholders in the community such as the County's Mental Health Board and the Lawyers Club of San Diego, and attendance at the Annual Meeting of the National Consortium of Torture Treatment. Program staff also made presentations to graduate level nursing classes and sociology classes at local universities. SOTI staff networked

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directly with the public by staffing tables at venues such as Amnesty International's Annual Human Rights Walk and Chula Vista Presbyterian Church's Annual Social Ministry Fair.

- In 2010, the County of San Diego Behavioral Health Services established regional behavioral and physical health collaboratives in an effort to increase integration and provide quality care coordination for clients served that included multiple health and mental health care providers. The partnerships help address gaps in resources and to create an informative network. Since the inception, various concerns and gaps among providers have been addressed, including but not limited to: the need for training and education of primary care providers on mental health clients being treated at primary care sites, and the need for mental health staff support and crisis intervention for clients presenting at primary care sites. Representatives at these meetings have included Behavioral Health Administration, Federally Qualified Health Centers, mental health clinic providers, hospital partners, Health and Human Services Agency (HHSA) staff, HHSA Aging & Independence Services, consumer operated programs, and other community partners. In 2011, Alcohol and Drug programs were invited to join. The collaboratives in North Regions, East, South and Central/North Central Regions continue to advance Agency initiatives such as *Live Well, San Diego!*, primary care integration with behavioral health, Low-Income Health Plan implementation, and also improve program knowledge with the participants.

OUTREACH AND ENGAGEMENT FOR CHILDREN AND YOUTH (CY-OE)

These programs serve children and youth, up to age 18, with serious emotional disturbance who are indigent and unserved or underserved and their families. Targeted outreach is made to Latino youth and youth involved in the juvenile justice system and associated community schools and children and youth with co-occurring disorders.

These programs offer outreach and engagement, assessment, medication management, case management, referral and linkage, co-occurring mental health/substance use treatment, and individual, group, and family therapy. Services are individualized, culturally competent, resilience focused, strength based, and designed to have families and youth actively participate in the development of their treatment plans.

School-Based and Home Services offer evidenced-based services at designated school sites during regular hours. Family services and services after school hours or during school breaks are offered in the home or office-based locations. Service providers work closely with school personnel to engage and support youth and their families in defining their vision and purpose, which then can be translated into strength-based goals. Juvenile Court and Community School services are designed to assist youth in returning to their home school districts in order to increase academic success. This program is dual-diagnosis capable, able to address substance use and abuse issues.

The programs address MHSA goals by increasing timely access to care for indigent children and youth who would otherwise remain unserved and/or underserved and by providing client and family-driven, strength-based, culturally-competent, and recovery-oriented services in school and community-based settings. The program strives to reduce institutionalization and promote integrated service experiences for clients and families.

FY 2010/11 Highlights

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- An important achievement that occurred in FY 2010/11 was around the modification of the delivery of the Incredible Years Parent Training (IYPT) model to make it more available to more families of preschool-aged clients. Prior to the modification, IYPT had been provided in group form at child development centers in the community, in both English and Spanish, in twelve-week increments. While the group model works very well for many families, for a variety of reasons, it does not work well for all because of transportation issues, parents availability due to working hours or are otherwise unavailable in the evening due to needs of their other children, some parents don't feel comfortable in a group setting or the timing or location of the group may not work in relation to the child's dates of enrollment in the program. To provide access to those who were previously unable to have access, the program began offering a modified form of IYPT which includes the same teaching strategies - viewing and processing video vignettes, reading and written exercises, and role-plays - but done one-on-one. Both the program clinicians or promotoras provide this modified version of parent training, and it can be done in the office or at families' homes, depending on need. An added advantage to providing services in the home is that it allows for hands-on parent support in the moment that they are struggling with their child's behavior, with immediate feedback. As a result, parents are more involved in their child's services than they may be if not accommodated, and this partnership works to the obvious benefit of the child.

System Development

System Development (SD) programs improve mental health services and supports for people who receive mental health services

SYSTEM DEVELOPMENT FOR ALL AGE GROUPS (ALL-SD)

These programs provide services to children, transition age youth (TAY), families, adults, and older adults who are unserved and underserved and have a serious mental illness or serious emotional disturbance. Targeted populations include individuals of Middle Eastern descent, Veterans, homeless individuals, Native Americans, children or TAY who are bilingual with a parent or caretaker who is monolingual, adults who are monolingual or not proficient in the English language, and adults who prefer to speak in their native language.

Programs offer a variety of services to individuals of all ages in the community including:

- Interpreter Services provides interpretation in multiple languages for clients and families receiving services by a clinician, case manager, psychiatrist, or other staff person at a mental health program. When services are requested, assigned interpreters travel to the program site to work with the client and care coordinator. In a situation identified as urgent, services are provided within four hours.
- Psychiatric Emergency Response Team (PERT) assists individuals in crisis that come to the attention of law enforcement. PERT seeks to optimize safe outcomes for these individuals through on-scene assessment, crisis intervention, referral, and access to appropriate services. Services are provided by a licensed mental health professional and a specially-trained PERT law enforcement officer. PERT clinicians also provide education and training to the law enforcement community. A PERT clinician also rides with the San Diego Police Homeless Outreach Team focusing on Veterans.

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- Chaldean Services focus on the Middle Eastern community who have not traditionally accessed mental health services due to cultural or language barriers. The goal of this program is to decrease stigma around mental health issues through provision of culturally competent services that increase well being and symptom management. Services are provided by bilingual and bicultural Middle Eastern mental health service professionals and include counseling, outreach and education, and training for mental health professionals on Middle Eastern populations and the manifestations of mental disorders in this population. The program collaborates with current mental health providers, Children's Welfare Services, Chaldean Catholic Church in El Cajon, Survivors of Torture & Trauma, law enforcement, and Middle Eastern providers of physical and mental health services in private practice.

These programs further the goals of the MHSA through the implementation of rehabilitation principles that are effective in reducing psychiatric hospitalization or incarceration by utilizing the least restrictive level of appropriate care and assisting unserved and underserved persons with a mental illness to become more productive community members. The services ensure timely access to mental health care and address the disparities gap for individuals of diverse multilingual communities. Service providers collaborate with County mental health providers, increasing service integration and coordination across the system.

FY 2010/11 Highlights

- Chaldean and Middle Eastern Social Services provided assertive outreach and engagement, mental health counseling, intake and screening and case management to 83 unduplicated clients. There were also 32 acculturation/welcome groups with 206 youth attending Arabic groups at the following East County Middle and High Schools - Cajon Valley High School, Cajon Valley Middle School, El Cajon High School, El Cajon Middle School, Emerald Middle School and Grossmont High School. There were parenting workshops for the parents whose children were enrolled in these acculturation/welcome groups. Also, there were monthly, in-office groups for youth, one for boys and one for girls, addressing anger management and acculturation.

SYSTEM DEVELOPMENT FOR CHILDREN AND YOUTH (CY-SD)

These programs serve children and youth, up to age 18, with serious emotional disturbance and their families. Special outreach is made to unserved and underserved populations including Latinos and Asian/Pacific Islanders, children and youth referred by the Probation Department and Kearny Mesa Juvenile Detention Facility, youth who reside in residential treatment facilities, and children and youth placed at home, foster care, or small group home at risk of a change in placement (i.e., placement at a higher level of care and therefore at risk of being removed from their home, foster home, or small group home).

This set of programs consists of a number of different programs designed to transform the mental health system.

- Family and Youth Peer Support and Partner Services hires family members to provide support, education, information, linkage to services, and advocacy for children, youth, and their families. This program offers leadership training opportunities enabling family and youth partners, who have experience with the mental health system, to serve as role models and leaders for the community. Other activities include treatment meetings, care planning, wraparound meetings, intake and assessments, case management, and home visits.

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- Crisis Intervention Services aim to prevent escalation, promote management of mental illness, increase safety, and reduce unnecessary and costly utilization of emergency and inpatient services. This program is staffed by one mobile team that provides emergency mental health evaluations, crisis intervention, linkage, and treatment plan development. The program refers and links individuals to services as an alternative/diversion to hospitalization when clinically indicated.
- Screening and Medication Management Services provide short-term stabilization treatment with psychotropic medication, case management, and linkage to on-going treatment. Services include psychiatric evaluation, consultation, assessment, and medication monitoring. The program also offers screening, brief interventions, and referral for clients with co-occurring disorders.
- Early Childhood Services provide family therapy for children age 0-5. The goal of this program is early treatment intervention in order to increase resilience of the child and family, prepare the child to function in school, and enable the child to interact appropriately with other children. Program staff led parent groups, parent and child interaction training, trauma intervention, and social skills training for young children.
- Supportive Services and Treatment Program works in conjunction with Child Welfare Services (CWS) and the Department of Probation to provide a full range of rehabilitation options designed to: 1) return children and youth to their family or family-like settings, 2) deter children and youth from being placed in a higher level of care, and 3) stabilize placement. Clients receive case management, assessment, life-skills training, therapeutic support for substance abuse issues, employment support, and specialized treatment. The program also includes a peer mentorship program. Peer mentors serve as a bridge to the adult environment by providing inspiration and hope as youth prepare to leave the San Pasqual Academy.

These programs advances goals of the MHSA by promoting rehabilitation and recovery for an underserved or unserved group of individuals, increasing client and family participation in service delivery by hiring family members to provide direct service and peer support, offering education to decrease stigma associated with mental health services, minimizing barriers and increasing access to integrated, family-driven services and supports and providing services for clients using the least restrictive environments.

FY 2010/11 Highlights

- The ChildNet program provided services to 131children at 42 different sites around North County. The services included child development centers, church preschools, elementary schools, in their homes, or in home-based child care facilities. Thirteen clients transitioned into kindergarten with good success with 10 of the 13 successfully meeting goals by discharge. Parents of 58 children discharged received Incredible Years Parent Training with good success. This number does not include parents of the 60 children who were still in treatment at the end of the year. The average rate of family participation increased from 73% in the previous year to 83% in FY10/11.
- Comprehensive Assessment and Stabilization Services (CASS) offered placement stabilization to 227 unduplicated clients by providing an outpatient mental health clinical program for children, adolescents, and their families of Severely Emotionally Disturbed(SED) youth served by Child Welfare Servces(CWS), who are at risk of change of placement from their home, foster homes, small group home, or other homelike setting. CASS provided continuity of care for youth and families during periods where services may otherwise have been disrupted. For example, there

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was a 7 year old girl who was hospitalized for several days and CASS was able to continue seeing her, support her family who was unable to drive from Fallbrook to San Diego to visit her in the hospital and understand what was going on (monolingual Spanish family) during this difficult time, as well as continue to coordinate, attend, and actively contribute to lengthy interdisciplinary meetings during the hospitalization to plan for her care. All of this would have been non-billable to Medi-Cal, but MHSA funding supported this essential continuity in such a high needs case.

- San Pasqual Academy is a residential education campus designed specifically for foster teens. In FY 2010/11, the Academy provided 137 foster teens with a stable, caring home, a quality, individualized education, and the skills needed for independent living. There were 30 young adults in the graduating class of 2011. For achieving academic excellence, demonstrating leadership skills and giving back to the campus community, three graduates received an Outstanding Citizen Award from the Academy's residential provider, New Alternatives, Inc. One of those awards included a car. Several graduates continued their education in vocational programs as well as two-year community colleges and four-year universities, including San Jose State University, San Francisco State University, California State University – Sacramento and Maryville State University in North Dakota. Approximately forty Academy youth are employed or participating in internships on- and off-campus. The Academy's Agriculture Program has been growing since 2004, and has been selling its certified, organic produce to local vendors such as Whole Foods under the name Dragon Organics. However in FY 2010/11, it entered the farmer's market arena with sales at farmer's markets in Scripps Ranch, San Marcos, Escondido and Carlsbad. The Agriculture Program provides an avenue for students to gain academic, work readiness and independent living skills. Youth take classes regarding the farm management, participate in harvesting and packaging the produce, work at the local farmers markets and educate their peers on campus about the benefits of eating fresh produce.

- The Caring Helpers program conducted educational presentation regarding mental illness to 1181 unduplicated clients. The program also conducted regional education forums, leadership training, and community health fairs for unserved and underserved populations as identified in the County's gap analysis. This program supports the principle of authentic consumer and family/youth participation thereby enabling the community to experience a positive perception of family youth with mental health issues. In FY 2010/11, the program developed iLEAD, a Leadership training, which teaches youth to teach other youth about ending bullying.

- The Juvenile Court Clinic, which provides short-term (up to three months) medication support and stabilization treatment with psychotropic medication and linkage to community-based or private on-going treatment, served 192 clients in FY 2010/11. It also assisted the child and family with support, linkage and coordination for ongoing mental health services if needed. The program provides consultation, reviews and feedback to the Juvenile Court regarding Form JV-220, an application regarding psychotropic medication. In FY 2010/11, the program assisted the court with over 1100 initial reviews of Form JV-220. Also in FY 2010/11, the program also assisted the then newly formed Juvenile Mental Health Calendar/Court as a sitting member of the screening committee and assisting clients with transition back into the community.

SYSTEM DEVELOPMENT FOR AGES 18 THROUGH 65+ (TAOA-SD)

These programs make up several services of varying focus and serves the unserved and underserved transition age youth (TAY, age 18 to 24), adults (age 18-59), and older adults (age 60 and above) with serious mental illness who may have a co-occurring substance abuse disorder, and their families. Special

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emphasis is placed on outreach and engagement to African-Americans, Latinos, Asian/ Pacific Islanders, Native Americans, women, individuals who are homeless or at risk of homelessness, individuals with a high incidence of emergency and inpatient service utilization, and individuals residing in board and care facilities, emergency shelters, and transitional housing programs.

These programs promote wellness and recovery goals, increase timely access and use of mental health services, develop self-sufficiency, and create support networks for clients through the following services:

- Outpatient Bio-psychosocial Rehabilitation clinics provide outreach/engagement, assessment, integrated dual disorders treatment, rehabilitation/recovery services, employment/education support, and psycho-education classes. Outpatient services have been enhanced to create levels of care, field capable services, psychiatric/primary care collaboration and increase the walk-in and urgent capacity at clinics.
- Clubhouses are member-run services that provide opportunities for skill development, social rehabilitation, and symptom management through an array of peer-led educational support groups and community activities. Three clubhouses primarily serve specific ethnic groups: Asian/Pacific Islanders, African-Americans, and Latinos; one is designed specifically for TAY.
- Peer Support and Liaison Services offer peer education delivered by peer counselors. Peers lead classes including Wellness Recovery Action Planning (WRAP) and other best practice curricula.
- Family Education Services offers a series of classes to educate/support families who have relatives with mental illness. This course is taught by families and increases coping skills while encouraging involvement with the mental health system. A 'train-the-trainer' component supports family members willing to become trainers. Classes target English-, Spanish-, Vietnamese-, and Arabic-language speakers.
- Supported Employment Services offers job screening, preparation, development, supports, coaching, placements, and employment opportunities. This program uses the SAMHSA evidence-based practice model for Supported Employment. The goal of this program is to assist individuals in finding and maintaining competitive jobs leading to recovery and independence.
- Patient Advocacy Program provides advocacy services to clients residing in licensed board and care facilities. These services include forming liaisons with staff and residents; providing information on community resources and the rights and responsibilities of residents and staff; conducting site visits; and investigation of client complaints and grievances.
- Mobile Outreach Services provides engagement, mental health/substance abuse screening, benefits information, linkages, and referrals. Services are offered 24/7 to isolated seniors in-home and to persons who are homeless, including on-site services in the community.
- Social Security Income (SSI) Support Services provides for the training and consultation of SSI. In their employed role as SSI advocates, consumers assist other consumers through the benefit application process. This service also provides benefits application training and support to advocates on preparation of a thorough and accurate SSI application.
- Walk-in Centers are voluntary, drop-in assessment centers that provide comprehensive and integrated assessment of mental health/substance abuse, crisis intervention, follow-up appointments, telepsychiatry, and medication management.
- Geriatric Specialist clinicians provide community based outreach services to isolated older adults, including age appropriate assessments of mental health/substance abuse and physical health

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needs; case management linkage and recovery services delivered onsite or via outreach and home visits. Clinicians also assist transition of stable clients to lower level resources.

These programs furthers the goals of the MHSA through implementation of rehabilitation principles proven to be effective in reducing psychiatric hospitalizations and assisting unserved and underserved persons with a mental illness to become more productive community members. These family and client-driven services also strive to reduce racial disparities in access to care, decrease the stigma of mental illness and empower peer and family involvement in the service delivery system.

FY 2010/11 Highlights

- Recovery Innovations served 3,744 unduplicated persons which exceeded their contract expectations to serve 1,597 unduplicated persons per year, with 98% of clients surveyed said that Recovery Innovations classes and services were helping them. Recovery Innovations also evaluates program success by surveying clients after their sixth visit, to determine their level of improvement in domains such as education, employment, recreation, housing, and personal relationships. Based on those surveys, through December 2011: 40% reported improved progress on their housing goals, 50% reported improved progress on their employment goals, 65 % reported improved progress on developing and maintaining friendships, 79% of clients improved progress on their education goals. In addition, the program collaborates with a wide number of advocacy services and service programs to produce an annual *Wellness and Recovery Summit*. A number of nationally known leaders of the consumer/client empowerment movement are brought to San Diego to speak at the Summit to approximately 400 participants, most of whom are consumers of San Diego County's public mental health services. The 2011 Wellness Summit was dedicated to discussing stigma faced by those having mental illness and ways to reduce that stigma. The day-long summit included a presentation by graduates of the Peer Employment Training on their vision of reducing stigma surrounding mental health challenges. The County of San Diego's *It's Up to Us* stigma reduction/suicide prevention media campaign was presented to the 460 people in attendance.
- The 13 clubhouses in the County of San Diego took action to improve their members' health and well being as a part of the *Live Well, San Diego!* initiative by offering comprehensive and dynamic programs of support and opportunities for people recovering from severe and persistent mental illnesses. Many clubhouse activities specifically target healthy eating and active living, which are important factors in improving the health habits and quality of life of their members. With a grant for Recovery and Wellness materials, the Escondido Clubhouse purchased Nutrition & Fitness Center/Food Education for People with Serious Psychiatric Disabilities, an evidence-based recovery curriculum from the Boston University. Several members reported that they lost weight, had a reduction in their blood pressure, reported their medication working better, were more active, and were sleeping better. At the Neighborhood House Association Friendship Clubhouse, members participated in softball tournaments sponsored by the Park & Recreation Department's Therapeutic Recreation Services. Friend to Friend Clubhouse Members living at the Downtown Safe Haven are offered classes such as diabetes management and meditation classes. Each Tuesday and Saturday, the Meeting Place provided its members with free fresh vegetables, fruit, eggs, and bread from donations provided by Trader Joe's. This allows members to have healthy food at home that they usually cannot afford. At the Oasis Clubhouse, members walked at Chollas Lake on a weekly basis giving members an opportunity to participate in a low impact aerobic workout while enjoying the outdoors. The Discovery Clubhouse modified yoga and volleyball by using a chair to address the needs of members with physical limitations. In addition,

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The Discovery Clubhouse provides smoking cessation groups once a week, to encourage clients to reduce smoking and use of tobacco related substances and to encourage substituting an alternative means of decreasing anxiety and symptom management independent of smoking.

- In order to promote better and more easily accessible care around the County, the walk-in outpatient services, which was available at the County's Crisis Walk-In Clinic at the Emergency Psychiatric Unit (EPU), was decentralized and moved to county and contracted adult and older adult outpatient mental health providers throughout San Diego County regions on September 1, 2010. The redesign increased walk-in and urgent capacity at the outpatient programs for clients who in the past would have been referred to the EPU Walk-In Crisis Clinic to access medication services and urgent/crisis services. During business hours, designated adult and older adult outpatient mental health clinics provided these services to all regions. The intent was to refer the adult or older adult client to the nearest outpatient mental health clinic where they reside. Emergency services remained available after September 1, 2010, and individuals continued to be able to access emergency psychiatric evaluation services at the EPU. However, the EPU will be for emergencies only and will not be providing outpatient mental health services such as medication refills.

Housing Program

The Housing Program finances the capital costs associated with development, acquisition, construction and/or rehabilitation of permanent supportive housing for individuals with mental illness and their families, especially including homeless individuals with mental illness and their families

The Department of Mental Health (DMH) and California Housing Finance Agency (CalHFA) Housing Program set aside approximately $33 million for San Diego County to leverage the development of permanent supportive housing. DMH and CalHFA approved the MHSA Housing Program application submitted by County of San Diego Mental Health Services for the first housing development:

The Housing and Community Development (HCD) MHSA Housing Notice of Funding Availability (NOFA) was re-issued on August 13, 2008, and revised on February 4, 2009, to reflect changes in DMH guidelines and decreasing affordable housing funding sources. One application for the NOFA funding was received in September 2009 for the North Star Cottage development by MHS, Inc., which set aside 14 two-bedroom units for the North Star FSP clients. The application is currently under review by HCD for consideration and recommendation to County for funding.

The CSS Enhancement #3 set aside $1 million for ongoing housing support for the FSP programs. Additionally, $1.7 million of one-time MHSA funds was utilized for housing support in FY 2010/11. These funds are embedded in several programs to facilitate an array of housing needs including short term, transitional and supportive housing.

The MHSA Housing Program is intended to guide the creation of housing opportunities for persons with mental illness in San Diego County, with a focus on developing at least 241 new units for MHSA-eligible clients with MHSA local and State housing funds. Three updates to the Plan have been published since the Plan was adopted, reflecting on both progress and challenges to meeting the goals. The current plan is located on the Network of Care Website (http://sandiego.camhsa.org/housing.aspx). The MHSA

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Housing Plan was prepared for and reviewed by the Mental Health Housing Council and reflects the input of clients, family members, developers, service providers and County staff.

FY 2010/11 HIGHLIGHTS

- Eleven housing projects with 194 MHSA units were in the development pipeline, representing 80% of the plan's development goal.
- 34th Street Apartments, with five MHSA units, completed construction and occupancy.
- Three developments totaling 58 units had been approved by CalHFA/ DMH for funding 6 and two of these projects totaling 48 units have begun construction.
- At the end of the FY, two projects, the Mason and 9th & Broadway, totaling 41 MHSA units, were awaiting approval by CalHFA/DMH. Also at the end of the FY, one development had submitted an application to HCD for local MHSA dollars. The remaining four projects are in various stages of predevelopment.
- For Leased, Partnership and Other Units: Mental Health Systems, Inc. and Community Research Foundation secured 50 new sponsor-based subsidies from the San Diego Housing Commission for vulnerable homeless persons with mental illness in the City of San Diego's downtown. The housing subsidies allowed the two Full Service Partnerships to provide services and permanent supportive housing to an additional 50 homeless individuals with serious mental illness. In addition, the County partnered with the United Way of San Diego County, the City of San Diego, and local non-profit organizations to provide services for 20 mentally ill homeless individuals who are frequent users of public resources. The County of San Diego Housing and Community Development Department prepared to issue a Notice of Funding Availability for project-based section 8 subsidies in the coming year. This provided an opportunity for MHSA developments in the County to leverage their capital dollars with much need operating subsidies.
- Improvement in client satisfaction with housing and services: Results from the 2010 focus groups and surveys were shared with the County and operators of Full Service Partnerships and used to improve the delivery of services and housing. The results from the 2011 focus groups indicated higher rates of satisfaction across the board with both housing and services.
- Planning for project lease-up: The County and its technical housing consultant, the Corporation for Supportive Housing (CSH), with input from the FSPs and the MHSA developers finalized and adopted the MHSA tenant application and referral process. Additionally, the County and CSH drafted a Memorandum of Agreement that will be used for all MHSA developments. It is an agreement between the County, developers, FSPs, and property management companies and it will serve as a guide for the collaborative partnerships of all parties to provide housing and supportive services to MHSA-eligible tenants. In FY 2010/11, the County and CSH established individual project planning committees (known as "Crosswalk" committees) for three new projects anticipated to open in FY 2010/11 or FY 2011/12, Townspeople's 34th Street Apartments, Squier/ROEM's Cedar Gateway and Father Joe's Villages 15th and Commercial. The Crosswalk planning model has been successful and will continue to be used as new projects move close to completion and occupancy. The County and CSH have established a "model" planning process that is being replicated in other counties.

The County's goal is to have at least 85% of MHSA FSP clients living in housing. As of July 1, 2011, over 90% of FSP clients were housed; 67% of the clients were living in permanent supportive housing, which

was a slight increase over the previous year where 66% of the clients were living in permanent housing. This includes the first five (5) clients to move into developed MHSA units.

FSP Clients Housing Situation as of July 1, 2011

Permanent Housing	**Number**	**Percent of FSP clients**
Developed MHSA Units	5	0%
MHSA Leased Units	259	26%
MHSA Partnership Units/Shelter Plus Care	109	11%
Clients with Project-Based Section 8	79	8%
Clients with Tenant-Based Section 8	36	4%
Clients in Other Affordable housing	41	4%
Clients without Subsidy	149	15%
Total Clients in Permanent Housing	**678**	**67%**
Other Housing		
Clients living w/ Family/Friends	54	5%
Clients living in Emergency Housing	11	1%
Clients living in Transitional Housing	79	8%
Clients living in Licensed Facilities (Board and Care, Long-Term Care Hospital, Assisted Living, etc.)	159	16%
Other (streets, unknown living situation, etc.)	34	3%
Total Clients in Other Housing Situations	**337**	**33%**
Total FSP Clients	**1015**	**100%**

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Prevention and Early Intervention

Reducing the stigma and discrimination associated with mental illness and providing preventative services to avert mental health crises

The Prevention and Early Intervention (PEI) component supports the design of programs to prevent mental illness from becoming severe and disabling, with an emphasis on improving timely access to services to underserved populations. Prevention programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue. To facilitate accessing supports at the earliest possible signs of mental health problems and concerns, PEI programs and strategies build capacity for providing mental health early intervention services at sites where people go for other routine activities (e.g., health providers, education facilities, community organizations). Mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness.

The following are FY 2010/11 highlights by PEI programs. For demographic information, please refer to Appendix B.

Primary & Secondary Prevention: Public Outreach, Education and Support Lines (PS-01)

Countywide public media campaign geared towards suicide prevention and stigma and discrimination reduction via education and outreach. Campaign also raises awareness of new PEI programs. In addition, this program provides countywide, confidential, peer-staffed support phone lines for youth, adults, and families.

COUNTY OF SAN DIEGO COMMUNITY HEALTH PROMOTION & AGING PROGRAM SPECIALISTS

County of San Diego Regional Community Health Promotion Specialists (HPS) and Aging & Independent Services Aging Program Specialists (APS) are tasked with bringing forth the agendas via outreach activities and education presentations throughout San Diego County.

In the North Regions, the HPS developed a regional communication tool on depression screening, developed a provider training packet and materials for Mental Health Month. As a result 50 individuals were screened for depression during Mental Health Month in the region.

In the South Region, the HPS assisted San Ysidro School District, National City School District and San Diego Unified School District in developing a "Wellness Policy." Many of the wellness policies listed above already have mental health and wellness written into the policy language. For example, San Ysidro School District's policy states the school must "provide all students with access to credentialed school counselors and psychologists who provide support and assistance in making healthy decisions, managing emotions, and coping with crises."

In the East Region, the HPS coordinated art classes with Rancho San Diego Library that featured 110 Intergenerational attendees. Inter-generations are children and seniors paired together to

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participate in diverse activities. The experience is meant to be socially and mentally enriching experience for the both generations.

In the Central Region, the HPS collaborated with Community Health Improvement Partner's Childhood Obesity Initiative and a Pediatrician Eating Disorder Expert with the purpose of educating mental health contractors and healthcare providers regarding the nexus between mental and physical health, specifically related to eating disorders. As a result, this was a topic of discussion at the annual "National Meeting of the Minds Conference" in November 2011.

The APS developed a presentation entitled "Good Mental Health is Ageless" which was debuted at the Southern California Council for the Blind Conference and the California Area Agencies on Aging Conference. The presentation was given to dozens of local community groups and seniors. The groups that received the presentation were asked to provide feedback. The results were that the information was presented in an understandable and simple manner rather than a clinical approach. The presentation increase awareness and the importance of good mental health to the aging and disabled communities.

Outreach Activities and Education Presentations by HPS/APS

Region	Outreach	Education
North	71	10
South	51	21
East	30	5
Central	119	37
APS	100	40
Total	**371**	**113**

HOUSING MATTERS

Housing Matters launched radio, television and print ads highlighting the benefits of supportive housing. The media campaign reached through regular broadcasting at an average of 84.4% of adults aged 21-54 and 98.2% of households. In addition, it reached through cable to 78.5% of adults aged 21-54 and 90.1% of households. Media outlets provided an additional $295,100

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in added value. There was an increase of general public awareness of supportive housing by 11% and an increased in acceptance of supportive housing by 7%.

IT'S UP TO US STIGMA & DISCRIMINATION REDUCTION & SUICIDE PREVENTION MEDIA CAMPAIGN

Phase 1 of the campaign began in June 2010 and continued in FY 2010/11. This phase consisted of outreach and education to inform primary care physicians and nurse practitioners about the campaign, prepare them for patient concerns regarding mental health and ensure that they understood how to recognize the signs of mental illness and/or suicide. Phase 2 of the campaign rolled out in September 2010. Phase 2 publicly launched the *It's Up to Us* campaign through mass media. This phase focused on stigma reduction and mental health literacy to encourage help seeking and supportive behaviors.

Research-based campaigns that utilize behavior change models can be effective in influencing knowledge, attitude and behavior. Findings from a 6-month follow-up study in March 2011, showed noteworthy changes (compared to the baseline study) in knowledge and behavior in San Diegans that recognized the *It's Up to Us* campaign ads. The 6-month follow-up study showed that 83% of San Diegans recognized the It's Up to Us campaign ads and 36% had discussed them with someone else, and 60% agreed that the ads helped them recognize symptoms of mental health problems. As result of seeing the ads, 84% were more likely to be supportive, 83% more likely to be respectful and 75% more likely to feel comfortable talking to a friend or family member about their mental illness. A significantly larger number of San Diegans who saw the campaign ads stated that they knew where to seek help (68% vs.48%), how to recognize warning signs for suicide (69% vs.48%) and agreed that people with mental illness should be hired just like other people (66% vs. 52%), and also agreed that they would be willing to socialize (76% v. 64%), work closely (67% vs.59%) with, and have with a person experiencing mental illness marry into their family (37% vs.27%).

Since the launch of the campaign on September 13, 2010, until June 30, 2011, there were more than 65,000 unique visitors to the campaign websites and more than 600 calls to the Access & Crisis Line (the County's primary access point for receiving mental health services), all known to be direct results of the campaign.

Part of the success of the *It's Up to Us* campaign can be attributed to the extent to which the campaign has been embraced by community members working in the mental health, stigma reduction, and suicide prevention fields. Regional health promotion specialists are requesting materials and distributing them through their networks countywide. Service providers are distributing materials to their clients and integrating them into trainings. The campaign website has been added to other resource guides and outreach materials. As a result, the media campaign messages are reaching community members who receive materials from peers and others they trust. In part, this success can be attributed to a very comprehensive stakeholder interview process, which listened to the community's views and wishes for the media campaign, and further offered them the opportunity to stay actively involved in the campaign design and implementation through an ongoing community input committee. Although this process can add additional time to the early planning phases of a campaign, there is tremendous value when stakeholders view the campaign as "theirs."

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SUICIDE PREVENTION ACTION PLAN

In 2009, the suicide prevention action planning process launched. The purpose of the Suicide Prevention Action Plan is to propose strategies that enhance efforts to increase understanding and awareness of suicide, decrease stigma associated with suicide and ultimately reduces the number of suicides in the County. In FY 2010/11, a needs assessment was conducted to provide local data and evidence to inform individuals, organizations and agencies across the County to take a strategic approach to suicide prevention at the local level. The report reviewed suicide and intentional injury data, and identified resources and gaps in existing suicide prevention efforts as well as provided recommendations for moving forward with the action plan. The findings were presented and discussed with over 200 participants at a forum held in January 2011. From January 2011 to June 2011, meetings with community members and stakeholders were held to identify and prioritize suicide prevention strategies. A draft Suicide Prevention Action Plan was submitted to the County at the end of FY 2010/11.

BREAKING DOWN BARRIERS

Based on Participant Assessment - Majority of the participants either "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (96.4%), "I am more comfortable seeking help" (94.2%), "I am better able to handle things" (95.0%). Majority of the participants either "Agreed" or "Strongly Agreed" with the statements, "After the presentation, I feel more knowledgeable about resources available for individuals" (95.7%), "After the presentation, I feel more comfortable dealing with today's topic" (97.7%), "The materials given out were helpful" (97.9%), and, "I feel my questions were answered" (98.2%).

FOTONOVELA – MOVING FORWARD/SALIR ADELANTE

The goal of *Moving Forward/Salir Adelante*, a fotonovela, is to develop, publish and distribute a fotonovela that will educate the Latino Community on mental health issues and how and where to access mental health services. The first meeting of the Fotonovela Steering Committee (FSC) was held on January 2010. The FSC consists of County of San Diego Adult/Older Adult Mental Health staff, program managers from County of San Diego service providers and mental health consumers. During the first meeting, the FSC laid the groundwork for the fotonovela. The FSC finalized two "storyboards" that outline the characters, relationships and overall theme of the Fotonovela story. In early February 2010, the contractor conducted focus groups throughout San Diego County to test the design, title, graphics and storylines with local San Diego Latino families. The contractor visited the San Diego area to photograph live actors for all of the scenes that will be included in the Fotonovela. In early June FSC gave its final approval to the script and design of the fotonovela in both English and Spanish. The printed fotonovelas were distributed throughout San Diego County in FY 2011/12.

ADULT/FAMILY & YOUTH/FAMILY PEER SUPPORT LINES

The Adult/Family and Youth/Family Peer Support Lines provide non-crisis peer phone support and referrals. The lines also provide mental health education. The support lines established a Memorandum of Understanding with the San Diego County Access and Crisis Line (ACL) in FY 2010/11. As part of the agreement, ACL added the program's toll free numbers to their

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brochure. The Family Support Line received and answered a total of 811 calls made during the hours of operation and 17 calls received outside the hours of operation. The Youth Talkline received and answered a total of 183 calls during operating hours and 6 calls outside the hours of operation.

Families as Partners (DV-01)

Families as Partners is a "Point of Engagement" Service with a South Region partnership between families, Child Welfare Services, and community service providers establishing a community safety net for the well being of the South Region's high-risk children and their families. Families as Partners program gives immediate provision of services and engagement with community resources and supports families to maintain a safe home and reduce the effects of trauma exposure. All of the participants served have been exposed to domestic violence and/or community violence or children whose parents are mentally ill or who may have had contact with law enforcement due to a crime or drug related offenses. Referrals come from law enforcement, Child Welfare Services, Domestic Violence Response Team, and/or community based organizations.

In FY 2010/11, the program strengthened the family and promoted stability by increasing the number of Families as Partners children who are diverted to prevention services by 20% (from 550 to 660). In June 2011, the program received the National Association of Counties (NACO) award.

South Region Trauma Exposed Services Program (DV-02)

South Region Trauma Exposed Services Program works with the Families as Partners program and other community partners in the South Region as a PEI Program. The program offers a variety of levels of evidence-based Positive Parenting Program (Triple P) practices to families in the South Region dealing with issues including domestic violence, chemical dependency, and abuse/neglect. The goal of the program is to detect any potential issues early allowing referrals to be made and reducing families' enrollment into the Child Welfare System (CWS). Triple P will be enhanced with comprehensive case management and linkage to appropriate community and specialty resources. The program is co-located in CWS South Bay Marina office with a unit from DV-01 Families as Partners program.

Alliance for Community Empowerment (DV-03)

Alliance for Community Empowerment (ACE) targets youth, siblings, and families of gang members or those exposed or at risk to exposure of violence. The goals of the program are to increase individual, family, and community resiliency; to reduce the impact of community violence and trauma; and reduce the negative impact of gangs. The program delivers its services through two components: 1) Direct Services to children-at-risk and their families and 2) Community Violence Response Team services.

In an effort to meet the needs of the community in FY 2010/11, the ACE Leadership Academy and Teen Empowerment programs continued to add more youth while serving existing participants. Flyers for the Strengthening Families series were distributed well in advance in order to reach as many potential participants as possible. Gang Awareness for Teens and Parents implemented a community Gang Awareness Assembly at Monroe Cark Middle School located in the City Heights neighborhood of Southeast San Diego. Mobile Response Teams were highly successful in responding to a variety of incidences including one shooting and a continuation of services for several family members of previous

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murders. Response Team members also continued to provide family support for court appearances which was a beneficial and much appreciated service to the community. Lastly, ACE recognized the need for a continuum of services and placed a focus on providing quality mentorship for many youth and parents during the summer months.

In FY 2010/11, 162 individuals were referred to the direct services component of the program. A total of 347 unduplicated youth and their families were served in the direct services component surpassing their goal of 220 unduplicated youth and their families. A total of 204 unduplicated families were directly served by the Community Violence Response team, meeting their goal to directly service a minimum of 200.

Positive Parenting Program (EC-01)

Position Parenting Program (Triple P) serves Head Start (HS) and Early Head Start (EHS) Centers to strengthen the skills of parents, HS/EHS center staff, and educators to promote the development, growth, health, and social competence of young children. Services are designed to benefit the child by working primarily with the parent/caregiver in collaboration with the Head Start staff to promote their education and enhance their ability to work with the child. Staff is also trained to provide on-going support to the family/caregiver once the Triple P curriculum is completed. The prevention model focuses on reducing the risk for behavioral/emotional problems in young children. Early intervention is done by providing assistance for parents of young children who are beginning to show behavioral or emotional difficulties. The program will serve the Central and North Coastal regions of San Diego.

During FY 2010/11, services were provided to a total of 1,157 unique families with children ages 5 years and below more than doubling their goal of 500 unique families with 99% of the parents' evaluated reported improvement in their parenting skills. Triple P served 26 Head Start Centers (HSC), exceeding the minimum target of 15, and worked with 4 Head Start Centers with significant military family enrollment. In addition, the program served 57 community sites which exceeded the goal of 6. There were 13 military community seminars conducted, six of which specifically focused on military caregivers in partnership with the Navy Region Southwest - Child Development Home Program. There were seminars in 38 low-income elementary schools, surpassing the 29 low-income schools reported the previous FY.

Kick Start (FB-01)

Kick Start provides services for individuals at-risk for developing or experiencing a first break of serious mental illness that includes outreach, education and intervention. The goal of this program is provide services to individuals experiencing the onset of mental illness and to reduce the potential negative outcomes associated with mental health issues in the early stages of illness. The target population is youth and TAY in the Central Region. This program was selected for the local evaluation of a PEI program.

In FY 2010/11, 125 presentations providing education and information on early detection of behaviors and symptoms that are risk factors for the development of psychosis were provided to over 900 community leaders. In addition, 211 telephone screenings providing an in-depth integrated assessment occurred and 62 clients were enrolled in the program. The Program Director gave a gatekeeper training to the Senior School Psychologist with San Diego Unified School District which resulted in an invitation to train all 140 School Psychologists in September 2011. Also, the program outreached to the following programs and agencies to set up educational presentations - KPBS, Boys and Girls Clubs at Clairemont,

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Logan Heights, Mercy and Linda Vista, Mira Mesa Youth Baseball, Rady's Children at City Heights, Arroyo Charter, Second Chance, Comprehensive Health Center, Young Life, Rose and Stein Education Center, The Center for Health and Wellbeing, The City Beat and Reader magazine.

Dream Weaver PEI Native American Consortium (NA-01)

The Dream Weaver PEI Native American Consortium, which is made up of four Native American health clinics, provides PEI services to the Native American Community within San Diego County. The Consortium casts a broad net to educate and inform community members about PEI activities. The PEI services are delivered through the Urban Youth Center, Elder Services/Navigator Program, and Outreach/Behavioral Health Prevention Education program with a special focus on Suicide Prevention by counselors, outreach educators, caseworkers, and elder navigators. The program serves all age groups from children to older adults. Outreach and prevention education activities promote and support community wellness, cultural activities, support groups, and referral services. Emphasis will be placed on enhancing individual, family, and community wellness by promoting and increasing awareness and access to cultural events that are known to support resilience. These services may include: traditional health gatherings, cultural programs that maintain language, knowledge of basket weaving (a local tradition for many tribes), nutrition programs, self-esteem activities, male involvement strategies, positive parenting, exercise programs, and the promotion of overall increased medical and dental health. All of these services will have the goal of preventing the onset of serious mental health problems.

In FY 2010/11, the program provided PEI services to a total of approximately 5,350 community residents. Due to the increased awareness of the numerous weekly wellness and cultural programs, community wellness increased among the target population.

One of the major highlights in FY 2010/11 at the Indian Health Council, Inc. is the Stitch to Wellness program which brings together people who enjoy quilting and while quilting conversations occur that surround the past history of individuals. Through Stitch to Wellness, individuals were able to get needed therapy, and it is helping to break stigma within the community. Another major highlight is the youth and elder potlucks in which the two generations interact together by talking and listening to each others' life stories.

The San Diego American Indian Health Youth Center provides a unique opportunity to enhance the quality of life for youth through cultural exploration, wellness activities and social interaction. By the end of FY 2010/11, 114 unduplicated youth received prevention services and 86 unduplicated youth received early intervention services which exceeded their program objectives of 34 unduplicated youth receiving early intervention services. The Youth Center hosted "Native Youth Honoring Our Elders: A Celebration of Wellness," a conference where elders, youth and families participated in prevention activities as well as recreational, cultural and educational activities. More than 400 people participated in the conference.

Elder Multicultural Access and Support Services (OA-01)

Elder Multicultural Access and Support Services (EMASS) program provides outreach, education, advocacy, peer counseling support and transportation services to older adult Hispanics, African refugees, African American and Filipino seniors by Promotoras, a Latin American approach that uses community peer workers, and community health workers. EMASS uses the threshold languages in many of their written materials and in peer education provided to the participants. Promotoras assist participants in

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understanding documents not in the participants' own language. The program seeks to identify and prevent mental health issues, reduce inappropriate utilization of services (such as emergency room visits), and increase access to healthcare services. This program offers transportation assistance to their participants.

During FY 2010/11, the program served 415 North County individuals, surpassing the goal of serving 400. The program served 300 Central Region individuals, surpassing the goal of serving 200. In addition the program served 200 South Region individuals, meeting its goal. In North County, transportation services were provided to 217 unduplicated clients, surpassing its goal of a minimum of 200 unduplicated clients. Additionally, EMASS worked with the International Rescue Committee to help more than 20 participants start the process of the U.S. citizenship. To date at least 10 have completed their paperwork and are awaiting their citizenship exam and interview, and 6 have already been sworn in as citizens.

Positive Solutions (OA-02)

Positive Solutions program helps homebound or socially isolated underserved older adults who are racially, ethnically and culturally diverse, who are at risk of depression or suicide redirect their lives to be more social and active, and to rediscover pleasure. The program adapted the evidence-based Program to Encourage Active and Rewarding Lives for Seniors (PEARLS) to help clients recognize symptoms of depression and teach them how to solve problems that contribute to the way they are feeling. Positive Solutions empowers these older adults to actively manage depression and improve their quality of life. Clients work with their counselor to outline goals and tackle solutions. They also plan a fun, physical and social activity for the week.

Positive Solutions had its first full year outcome in FY 2010/11. Through this whole year, PSP has served 814 unduplicated seniors in both San Diego Central Region and North County. Moreover, 86.19% of seniors who received brief intervention services have shown risk and symptoms reduction, and 43.65% have at least 50% of symptoms reduction compared to 43% for the original PEARLS study. Based on the client satisfaction survey, 94% expressed overall satisfaction with the program.

Aging Well (OA-03)

Aging Well delivers age-appropriate, culturally and linguistically appropriate, educational activities and materials about mental health to older adults, family/caregivers, and health and social services providers. Program staff presents lectures and materials at community senior centers, adult day health centers, senior low income housing, and faith-based community organizations.

In FY 2010/11, Aging Well was translated to an eLearning course. The target number to provide aging education was to 500 people. Three hundred and thirty (330) people, 66% of the goal, were trained, with 97% of the participants stating that they increased their knowledge about needs of seniors. Participants were satisfied with the education program and as a result of the training they knew where to get support and help.

REACHing OUT (OA-04)

REACHing Out program is a multifaceted, personalized intervention intended to prevent or decrease depression symptoms due to isolation and burden of care in Hispanic caregivers of Alzheimer's patients.

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The program intervention includes nine home visits, three 30 minute telephone check-ups, and five structured telephone support sessions for caregivers by a trained project staff member.

During FY 2010/11, there were 160 Hispanic caregivers enrolled in the REACHing Out program. All of the caregivers were of Mexican/Hispanic/Latino origin. A majority were Mexican American/Chicano (81.9%), with several identifying as Cuban, Dominican, or Other Hispanic. There were no Puerto Rican or Salvadoran caregivers. A majority were also female (95.6%), and under 60 (68.9%). The mean age of caregivers was 54.4.

All of the caregivers responded to an assessment and a reassessment about their health after receiving the REACH intervention. At the reassessment, 72.7% of caregivers reported that they were in "Good" or "Excellent" health, compared with only 56.2% at the initial assessment. Caregivers were significantly less likely at the reassessment to indicate that their health was standing in the way of doing the things they wanted to do. At reassessment, fewer caregivers were at high-risk for depression than at the initial assessment (28.2% vs. 58.7%).

During FY 2010/11, REACHing Out made some design changes by ending a partnership with one of their subcontractors and worked to recruit another partner in the Region. This resulted in working with only one partner agency for several months and this significantly reduced the number of referrals to the program's Care Managers and hence, reduced the number of clients served though Early Intervention activities. This programmatic change, although a challenge in the short term, was necessary to ensure the long term success of the REACH program.

Salud (OA-05)

Salud provides integrated care for mental health and medical conditions to Hispanic older adults. Early intervention includes integrated diabetes/depression care management by a Master's level RN, and intervention is delivered in primary care settings.

In FY 2010/11, statistics indicate that the program was achieving the goal of reaching persons who might not otherwise receive treatment as almost 90% were not receiving any other mental health services. In FY 2010/11, 142 participants enrolled in the program. In addition, patients from SYHC have access to a care coordinator who monitors their diabetes and mental health concerns and engages them in Problem Solving Therapy (PST) to help treat their depressive symptoms. The program design supports the development of integrated care for diabetic clients experiencing depression by assigning responsibility for mental health and medical care to one single care provider. In FY 10-11, 36 clients received PST services.

SmartCare (RC-01)

SmartCare also known as the Rural Integrated Behavioral Health and Primary Care Services program includes assessments and short-term interventions in rural community clinics for individuals who may be at risk for or are in the early stages of mental illness. The program goals are to prevent patients in rural community clinics from developing an increased level of behavioral health issues, severe mental illness, or addiction. The target population includes children, adolescents, transition age youth, adults and older adults in community clinics located in rural areas of San Diego.

In FY 2010/11, the first year of the program, wellness activities reached more than 2,100 rural community members who participated in 143 events. English and Spanish presentations covered topics including nutrition and exercise, mindfulness, meditation and yoga, budgeting, volunteering and job

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readiness, character education and bullying prevention as well as anger management and other specific trainings requested from within the rural communities. SmartCare's behavioral health staff actively participated in pre-existing community events such as the Yellow Ribbon Suicide Prevention Walk, National Food Day, various health fairs and fitness programs. Events were strategically held in community centers, schools, senior centers, and Boys and Girls Clubs in an effort to provide outreach in areas where individuals are known to come together for social and educational purposes in a comfortable and familiar environment. Other community partnerships and collaborations included the Sheriff's Department and CASA (Center on Addiction and Substance Abuse) to provide Red Ribbon activities in schools and to assist with Prescription Drug Take Back Day, San Diego County's Elder Services to bring the Healthier Living Chronic Disease Self Management Program to the community, the Lions Club to ensure glasses to Spanish Speaking individuals, libraries to create a book exchange to families without transportation and local hospital and school districts to assist with diabetes/obesity screenings of fifth graders. The Ramona Patch, a local on-line news source, requested permission to publish the SmartCare blog on their site.

School-Based Program (SA-01)

School-Based Program provides a family-focused prevention and early intervention plan for school age children and their families in high risk communities with high ratios of Asian/Pacific Islanders and Latinos and socio-economically disadvantaged families in North and East Region through its unique design of school and family components. School component served children and their families in by providing social-emotional mental health evidence-based prevention and early intervention services. The Positive Behavioral Support (PBS) is implemented through the Building Effective School Together (BEST) model and Incredible Years (IY), and a family component focused on resiliency is delivered through community outreach specialists (COS). Interventions are coordinated to increase resiliency and protective factors for children by improving child/parent social and emotional skills and reducing parental stress. The aim is to minimize barriers to learning while supporting children in academic and personal success.

In the FY2010/11 academic year, the North Region program served 2,020 unduplicated preschool-third graders, exceeding the 1950 minimum required, at the four targeted elementary schools – Rose and Pioneer Elementary in Escondido, and Mission and Laurel Elementary in Oceanside. There were 92 classrooms served weekly throughout the year, receiving a total of 34 lessons. Of the 624 children screened, 550 children received early social/emotional evidence based practices (EBP) interventions, with 365 of their parents reporting that 88% of their children decreased the frequency of disruptive behaviors in the home. In addition, 2941 children participated in BEST, which exceeded their target goal of 2700 children. In Mission Elementary, there was a drop in office discipline referrals by more than 50%, with only 106 referrals versus 218 in the 09/10 academic year, and suspensions decreased by 82%. In Laurel Elementary, there were 78 fewer referrals as compared to the 09/10 academic year, and a significant reduction in suspensions by more than 36%. Through the family component, COS conducted outreach activities on a weekly basis on site at the four schools to establish familiarity with the program among school families. One barrier that was experienced was difficulty contacting some of the parents of children referred. The program strategized with the school and have collaborated with the principals and teachers to gain access to some of the more challenging and resistant parents.

In the FY 2010/11 academic year, the East Region program enrolled 937 children (108.1% of goal) with PBS, 716 children (119.3% of goal) with IY prevention-based classroom curriculum, 174 children (96.7% of goal) with IY early intervention group curriculum, 516 parents and adult family members

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(160.9% of goal) received PEI services and 662 community referrals were given out to families in need of additional services. During the 10/11 academic year, layoff notices were given to more than 100 teachers and support staff. As a result, teachers and support staff reported significant increases in stress levels, which affected their performance and willingness to go above and beyond for the program. The program manager met with the schools to address how the program could support the schools during budget cuts, and helped refocus everyone's energy onto the children, families and community.

Suicide Prevention Education Awareness and Knowledge (SA-02)

Suicide Prevention Education Awareness and Knowledge (SPEAK) is a suicide prevention program to serve students through education, outreach, screening and referrals in schools. It includes education to school staff and families. The program goals are to reduce suicides and the negative impact of suicides in schools and to increase education of the education community and families. The target population is children, youth, TAY, schools staff, gatekeepers, families and caregivers.

In FY 2010/11, the first implementation year of the program, 318 suicide prevention education presentations were provide at 30 schools and community groups. *Ask for Help*, suicide prevention for youth presentation, was given to 9,173 students and *Be a Link,* suicide prevention training for gatekeepers, was given to 2,245 San Diego Unified School District staff and 245 parents. A student survey with outcomes through December 2010 resulted with 86.4% of students knowing where to get help and 65.5% of students feeling comfortable getting help.

Courage to Call (VF-01)

Courage to Call program is a confidential, peer-staffed outreach, education, and training services to the Veteran community and its service providers. The program goals are to increase awareness of the prevalence of mental illness in this community, reduce mental health risk factors or stressors, and improve access to mental health and PEI services, information and support. The target population includes Veterans, active duty military, Reservists, National Guard and family members.

During July 16 & 17, 2010, Courage to Call participated in *Stand Down* for homeless veterans, a community-based intervention program designed to help the nation's estimated 200,000 homeless veterans "combat" life on the streets. San Diego has the largest number of homeless veterans nationwide. During this weekend event, Courage to Call made contact with over 200 Veterans, their families and networked with other providers that delivered services to this population. The *Stand Down* from October 12, 2010, was featured on the television show, *60 Minutes*. The following is the link to the feature http://www.cbsnews.com/video/watch/?id=6966795n. Also Mental Health Systems, Inc., Veterans Village of San Diego and Mental Health America participated during this event.

The executive branch of the State of California and the federal government have created treatment and support programs intended to benefit military veterans suffering from mental health issues stemming from their service in the United States Military. The mental health problems addressed by these programs include post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), military sexual trauma (MST), depression, anxiety disorder, and other mental health conditions (referred to collectively as "Military-Related Mental Health Problem(s)"). Some veterans who suffer from Military-Related Mental Health Problems are defendants in pending criminal cases in the San Diego Superior Court (SDSC).

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The Veterans Treatment Review Calendar Pilot Program (VTRC Pilot Program) utilizes the collaborative approach to establish a comprehensive program that simultaneously responds to veterans' needs and promotes public safety. This approach to the adjudication of veterans with military-related mental health problems promotes accountability through a combined program of judicial supervision, justice partner collaborative efforts, and appropriate treatment and support. The San Diego Superior Court began hearings on February 4, 2011 to divert justice-involved veterans into mental health treatment programs in lieu of incarceration. As of June 30, 2011, twelve (12) veterans were participating in the VTRC Pilot Program, all with mentors, and all 12 are sustaining their mental health treatment.

"From Warrior to Soul Mate Weekend Couples Retreats" for Active Duty and Veteran Couples are designed to increase marital/relationship satisfaction, communication, and emotional literacy skills, based on a proven, evidence-based model called Practical Application of Intimate Relationship Skills (PAIRS). Active duty and veteran personnel and their families face a variety of unique challenges, and therefore need access to a variety of evidence-based interventions at various levels of care. Returning veterans are subject to increased marital discord, divorce rates, and suicidal thoughts associated with distressed relationships. It is not used with extremely troubled marriages, not for couples experiencing domestic abuse, drug abuse or where there is clear psychosis. The Veterans Affairs Chaplain Service in Augusta, GA has shown significant and impressive results for veterans using the PAIRS model. From May 2010 to September 2010, the VA San Diego Healthcare System piloted this model through four workshops for over 100 couples. The evaluations were extremely positive, with couples who attended each retreat stating that the weekend had saved their relationship from ending. With one-time MHSA funding, the program was designed in the spring of 2011 to reduce the backlog of 80 couples on the VA San Diego Healthcare System's waiting list due to a lack of VA grant funding. As of June 30, 2011, 52 couples attended two retreats held at the Kona Kai Resort and Spa in San Diego on the weekends of May 13-15, 2011 and June 10-12, 2011. The satisfaction scores were 4.5+ (5 being the highest) and 75% of the couples were active duty military.

Participants also completed a free text response to express their appreciation for what they had received from the weekend couples retreat. Copied below is an example of a the positive responses that were received:

> *"The Warrior to Soul Mate has saved my marriage from ending in a divorce. This retreat has given me valuable communication skills and relationship skills that I can use to keep a happy and healthy relationship with my husband. Not only does this help my marriage but my young babies will learn this skill from me and hopefully break the cycle of divorce that seems to run in my family. I am so thankful to have had the opportunity to come to this retreat. I could not have afforded this on my own and I gave up on marriage counseling. My relationship with my husband still needs work but now I have hope that we can make it through anything. My dream of growing old with my husband and watching our children grow and thrive with their own relationships have been restored. I want to thank you from the bottom of my heart. Words cannot express the hope and joy I feel with my husband after this retreat. Thanks for all the time and effort put into helping us."*

Bridge to Recovery (CO-01)

Bridge to Recovery provides screening, brief intervention, education, linkages, and referrals to transition age youth, adults, and older adults. The program also offers peer case management support to clients

who need treatment or additional resources. Services are provided on-site at the San Diego County Psychiatric Hospital to individuals with low mental health needs and high substance abuse issues. Individuals served at the hospital are indigent, often homeless, highly vulnerable and disenfranchised.

During FY 2010/11, Bridge to Recovery's work was noted to be the Gold Standard by SAMHSA during a site visit. It was acknowledged the relationship between Bridge to Recovery and the County hospital staff was seamless and added to the success of patient care. The Bridge to Recovery featured the Peer Volunteer Program with peer volunteers who were UCSD COD Program graduates. These volunteers engaged new patients by facilitating pre-treatment groups three times a week, and throughout the year they participated in community outreach activities such as Project Homeless Connect, the NAMI Walk and Walk for Recovery events.

Co-Occurring Disorder – Screening by Community Based Alcohol & Drug Services Providers (CO-02)

Screening by Community Based Alcohol & Drug Services (ADS) Providers places mental health counselors in ADS contracted programs to identify and screen clients who exhibit mental health concerns prior to their development of a serious mental health diagnosis and to provide PEI services. Thirteen treatment and recovery programs receive funding and the following underserved racial/ethnic and cultural populations are served in individual programs, including:

- Trauma Exposed Individuals
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Children and Youth in Stressed Families
- Children and Youth at Risk for School Failure
- Children and Youth at Risk of or Experiencing Juvenile Justice Involvement

Underserved Cultural Populations, including Asian and Pacific Islanders, and Lesbian, Gay, Bi-Sexual, Transgender and Questioning (LGBTQ).

A Quiet Room was added at the Vista Hill Parent Care Therapeutic Learning Center. The Quiet Room was integrated as part of therapy during the one-on-one sessions with the children. The Quiet Room was extremely successful in aiding the child's focus and redirection. The children began to identify and utilize the Quiet Room as a safe place for retreat when they were feeling anxious, upset or wanted to relax.

During FY 2010/11, Stepping Stone accomplished the goal of providing individual psychotherapy to every client in treatment. The program increased client engagement and retention that decreased the client's chances of relapse. Overall, the program grew and saw a tremendous positive effect on the culture of the program and the dedication of the treatment team. One of the greatest challenges of working with co-occurring disorders is stigma. Clients sometimes come into the program having been stigmatized by loved ones and/or society. This may be presented as shame. The mental health counseling program used individual and group treatment to address the shame and the stigma in clients.

At the Palavra Tree, approximately 40 to 60 clients were treated every month and 150 service hours were administered monthly. The program used a multi-faceted treatment strategy to impact successful mental health treatment in clients. Many clients are poly-substance users that report using alcohol,

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methamphetamines, cocaine, ecstasy, etc. The Mental Health Clinicians provided services such as psycho-educational, motivational, movement groups and parenting groups as part of the treatment strategy.

The Phoenix House Teen Recovery Center and Academy served 91 unduplicated youth (82% of goal), and offered services to 140 family members (87% of goal).

Statewide Training, Technical Assistance and Capacity Building

In 2008, the MHSOAC approved the funding level of $6 million each year for four years for the Statewide PEI Project that would be administered by counties; San Diego County's allocation is $508,800 annually for four years. Behavioral Health Services initially requested, and subsequently received, this funding in June 2009.

The primary goal of the Statewide Training, Technical Assistance and Capacity Building (TTACB) Project is to improve the capacity of local partners outside the mental health system (i.e., education, primary health care, law enforcement, older adult services) as well as County staff and partners who work on the development, implementation and evaluation of prevention and early intervention programs that are funded through the County's PEI plan.

Counties may utilize training technical assistance and capacity building methods that have demonstrated the capacity to increase skills and promote positive outcomes consistent with the MHSA and the PEI guidelines.

PEI PREVENTION WORKS: A CONVENING OF SOUTHERN CALIFORNIA COUNTIES

San Diego Behavioral Health Services in partnership with Southern California Counties identified the need to increase awareness of prevention and early intervention efforts and share successes and challenges across the southern region. The first activity funded through PEI TTACB, *Prevention Works: A Convening of Southern California Counties,* was held January 26, 2011. Our vision was to create an opportunity where all PEI stakeholders including, but not limited to, administrators, programs, educators, and community members could engage in a focused dialogue related to prevention and early intervention efforts across counties. Over 120 people dedicated to improving the overall health and wellbeing of unserved or underserved populations came together at the *Prevention Works Convening*. A report was developed which incorporates the shared successes and challenges of implementing specific PEI programs, strategies on data collection and evaluation, and solutions discussed during this event. This tool is available statewide through the California Institute of Mental Health's website.

There are several training, technical assistance and capacity building events in the pipeline, including Impact of Violence and Trauma in Communities, Supporting Community College Students, Spirituality, Cultural Competence, and young children.

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Innovation

Developing and implementing promising and proven practices to increase access to mental healthcare

San Diego County has completed two community program planning efforts, known as cycles, in order to develop innovative programs. After an extensive series of community forums and based on stakeholder input, in December 2009 (Cycle #1), staff developed an Innovation Program and Expenditure Plan that described the initial five (5) new short-term projects with novel and creative mental health practices and approaches. In Fiscal Year 2010/11, utilizing the Mental Health Services Oversight and Accountability Commission's *Decision Path for Counties* as a guide for the community planning process, five (5) additional projects were developed (Cycle #2). Of the ten (10) projects, three (3) programs provided services in Fiscal Year 2010/11. A discussion of each of these and its progress is below.

Cycle #1 includes the following projects:

- Wellness and Self-Regulation for Children and Youth (INN-01)
- Peer and Family Engagement (INN-02)
- Physical Health Integration (INN-03)
- Mobility Management in North San Diego County (INN-04)
- Positive Parenting for Men in Recovery (INN-05)

Cycle #2 include the following projects:

- After School Inclusion (INN-06)
- Transition Age and Foster Youth (INN-07)
- Independent Living Facilities (INN-08)
- Health Literacy (INN-09)
- In-Home Outreach Teams (INN-10)

Wellness and Self-Regulation for Children and Youth (INN-01)

This project integrates therapeutic experience for children in an existing program (e.g., residential or day treatment, school site) that uses a number of innovative activities to address overall mental and physical wellness.

Contracts were awarded in October 2010 for this project. *Project Evolve!,* named by the teen participants, offers an array of alternative, holistic intervention to produce a positive impact on mental and physical health. These interventions strive to help teens improve the quality of their arousal level, mood, physical health, mental health, social functioning, sleeping patterns, and sense of self. The program focuses on teaching children skills that effectively help them regulate themselves in all areas of their lives.

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Project Evolve! focuses on five areas of wellness. These areas are nutrition, fitness, spirituality, meditation/yoga/relaxation, and socialization. Activities in all of these areas are now part of the regular 7 day a week programming. These activities include yoga, tai chi, fitness groups, recreation therapy, nutrition education, horticulture therapy, food preparation, wellness drumming, theater, equine therapy, spirituality and culture groups, trivia Tuesdays, and more.

Family involvement is another component of the Wellness Program. Family night is held once a week. Families, mentors, and other supportive people in the teens' life are invited to share a meal and an activity. Each activity focuses on an area of wellness. This supports the wellness of the families and also demonstrates how the families can support the teens in their pursuit of wellness.

Since its implementation menus have been revised to include fresh, natural foods and a daily salad bar. The teens are now eating more vegetables and less fried foods. A campus garden was created where the teens plant and tend vegetables and fruit, and learn about science, art, and literature. Since the Wellness Program's implementation the teens have lost over 1000 pounds, decreased cholesterol by 300 points, and experience healthy weight change at 40% or higher each month. Healthy weight change is defined by overweight and obese teens losing weight and underweight teens gaining weight.

The teens themselves have expressed their surprise at enjoying healthy foods, feeling healthier and learning new things. By trying new things the teens have discovered that they like activities that they would have never imagined. These activities offer the teens new coping skills. Teens ask to walk in the garden, practice deep breathing, beat on a drum, or exercise when they are feeling frustrated. They were surprised to learn that the attitude of non-violence learned in tai chi can assist them in overcoming their life's challenges. The teens were surprised to discover that broccoli grows right out of the ground and that they can eat a tomato right off the vine. They became more aware of how the world functions as a whole.

Residential staff has commented that the kids are stronger and happier than before. School staff reports that the teens are more focused in school and that reading levels have improved. The psychiatrist on staff reported that the teens look fit and that the requests for gastrointestinal aides and complaints of gastro problems have decreased significantly.

The staff is also benefiting from the Wellness Program. As they witness and support the Wellness Program they too are becoming more invested in their own health. They are motivated to make change and to be positive role models for the teens. In addition, the Wellness Program's socialization component promotes a process-based structure for the campus. The Staff have been trained in techniques that emphasize the strengths of the teens. These techniques teach the staff ways to assist the teens in claiming ownership of their lives and problem solving how to reach their goals and find healing. These techniques are successful in resolving conflict with the teens and decrease the need for more assertive interventions

A sampling of lessons learned includes:

- Detailed notes of the client's participation in Wellness groups have provided valuable information in regards to the client's symptoms and progress in treatment. For example, some children escalate very quickly in music groups, but not other relaxation groups like yoga. This is often due to sensory overload associated with autism spectrum disorders. This information is taken to the

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treatment team and the expectation for that client in relation to certain groups is modified. Individualizing treatment to meet the client's unique needs is crucial to the success of the program and getting the therapists on board with the program. The main point of this is that not all groups are for everyone.

- Offering age-appropriate groups is most important for the success of the Wellness Program. The nutrition classes originally were similar to classroom learning. Clients became easily bored, escalated, and defiant. Adjustments were made to be more focused on gardening and healthy cooking, which has continued to teach nutrition, but in a more fun and appropriate way.

- The amount of medications assessed does not appear to accurately represent the client's improvement. Clients will often be on a lower dose of medication upon discharge, or have changed to a more mild medication, but the amount of medications they are on remains the same according to the current output data.

Dance and therapeutic art are activities that are scheduled to be implemented next. The teens are sharing more and more ideas of ways to bring wellness to campus. A comprehensive report will be developed at the end of this program with a thorough discussion of the challenges, barriers and how those barriers were overcome, and the valuable lessons learned.

Peer and Family Engagement (INN-02)

Now called Hope Connections, this peer and family engagement project began in July 2011 (Fiscal Year 2011/12). Hope Connections consists of integrated teams of transition age youth, adult, older adult and family peer support specialists that provide a number of services to new mental health clients and their family members prior to their first visit to the clinic. One team also serves individuals and their families in the County Emergency Psychiatric Unit.

Team members welcome clients and families to the outpatient mental health system emphasizing the hope for recovery and the ability of the client to take an active role in fulfilling personal recovery goals. Every time a new client is referred to an outpatient clinic, they are asked if they would like to involve their family, which may require a field visit. By engaging clients and families prior to their clinical intake, it is anticipated that the entire treatment experience will be cast in a significantly different manner.

Additional information about the progress of this program will be available in the Fiscal Year 2011/12 Implementation Progress Section of the Fiscal Year 2013/14 MHSA Annual Report.

Physical Health Integration (INN-03)

With a three-month initial startup, the Physical Health Integration Project, now called ICARE (Integrated Care Resources), began seeing clients in March 2011. ICARE is an innovative pilot project to create person-centered medical homes for a minimum of 600 individuals with serious mental illness (SMI) in a primary care setting. The goal of the project is to enhance overall mental and physical wellness for individuals with SMI by increasing access to physical health care and reducing the stigma. There are two subsets of participants in this project. One group consists of clients that mental health clinical staff identifies as having stable mental health and ready to transfer to a specific health center for comprehensive physical and mental health care. The other group are those who continue to receive

mental health treatment at a mental health program and receive physical health care from a specified primary care clinic. Areta Crowell Center serves as the mental health program site. The three primary care clinics participating are in North Park, Logan and City Heights.

Start-up included the building of an exam room within the mental health site, hiring of an Alcohol and Other Drug counselor and Peer Support Specialists, participation in the University of Massachusetts' Certificate in Primary Care Behavioral Health Care course, and solidifying efforts in program evaluation tools and measures with the USCD Research team.

Notable challenges include:

- Finding a Nurse Care Coordinator that could effectively perform in a mental health setting was a considerable challenge.
- Transitioning clients from mental health site to primary care took longer than expected. To assist in the transfer process, clients who are foreseen as nearing transition criteria are now receiving more information about the process earlier in their treatment and the establishment of the program and regular interaction with ICARE staff at the mental health site has built a level of confidence and trust with those who facilitate the transition.

A comprehensive report will be developed at the end of this program with a thorough discussion of the challenges, barriers and how those barriers were overcome, and the valuable lessons learned.

Mobility Management in North San Diego County (INN-04)

This Mobility Management Program began August 2011 and provides peer-based information sharing and support to assist clients with transportation options. A volunteer peer ride share program also enhances client mobility. The program lead coordinates resources and collaborates with the transportation community. Positive changes are anticipated on two levels by participating in this program. First the participants will increase their independence and ability to attend health and social activities in the community. Participants may also form support networks and friendships with the travel buddies, strengthening their social skills and enhancing resilience and hope for recovery. Second, we will learn if coordination of transportation resources and involvement with the transportation community leads to an improved transit system and increase mobility for mental health clients.

Additional information about the progress of this program will be available in the Fiscal Year 2011/12 Implementation Progress Section of the Fiscal Year 2013/14 MHSA Annual Report.

Positive Parenting for Men in Recovery (INN-05)

This program began July 2010 and offers a unique parenting enrichment program for fathers in Alcohol and Other Drug (AOD) treatment programs in order to improve their parenting skills, provide education on mental health, and understand the impact of trauma and violence on their children and families.

Many men receiving treatment for substance abuse suffer from depression, high levels of stress, and loss of self-esteem. Many also have a history of childhood abuse and neglect. An important goal of substance abuse treatment is learning how to maintain healthy relationships. This is directly related to parenting, as a critical skill for parents is learning how to nurture relationships with their children. The

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knowledge, skills, and ability to provide a healthy environment for children are lost when a parent is struggling with addiction leading to high rates of child maltreatment. This parenting program for fathers will test the efficacy of an integrated approach that combines education on mental health, wellness and substance abuse with parenting skill building.

More parenting resources for men in AOD treatment was an unmet need prior to implementation, and having this element now complements AOD treatment and appears to enhance treatment motivation and retention for the men who participate in the program. The parenting component has been very well received by the men who participate. Addressing men separately on the topic of parenting has been an important learning point. For example, many of the participating fathers will be raising children on their own for the first time with the mother being absent and these fathers are learning how to bond and the importance of bonding with their children.

The program has had some challenges. Forming new parenting groups and fostering growing participation have been challenging, as well as raising clients' comfort level around parenting issues, and helping men to be comfortable around other men in group sessions.

The program has been modified to take into consideration men's gender specific needs. For instance, programs have instituted potluck gatherings specific to these groups that are considered a highlight by the clients, integrating food and celebrations into the program and promoting AOD-free pro-social activities.

A comprehensive report will be developed at the end of this program with a thorough discussion of the challenges, barriers and how those barriers were overcome, and the valuable lessons learned.

After School Inclusion (INN-06)

The essential purpose of this program is to increase access to after-school programs to youth with social-emotional/ behavioral issues who have been prevented from attending, discharged from, or at risk of discharge from inclusive after-school programs. This project will measure the impact on youth, and their families, of the benefit derived from access to normalized existing integrated community-based after-school programs with the goal of leading happier, healthier, less stigmatized lives as a result of this program.

This program will also increase access to other services for participants by enhancing gatekeepers (after-school program staff) awareness of how to identify at-risk youth and refer them to appropriate support services, which will allow youth to benefit from earlier intervention.

This program is expected to begin September 2012. Additional information about the progress of this program will be available in the Fiscal Year 2011/12 Implementation Progress Section of the Fiscal Year 2013/14 MHSA Annual Report.

Transition Age and Foster Youth Program (INN-07)

This innovative program is expected to begin July 2012 and is expected to improve outcomes by incorporating three (3) interactive components: Coaching, Mentoring and Teaching. Within the teaching component, staff will impart specific knowledge of, or skill in, identified areas. Within the coaching component, staff will focus on giving instruction or advice on identified issues and in the mentoring

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component, the staff strength will be on developing relationships with participants with an aim to increase trust, support and positive influence.

Participants of this program will identify individualized goals and choose activity modules that address those goals. This project expects to reduce the following problems and barriers that were identified by a community planning process:

- TAY lacking self-identity, sense of purpose and passion for future
- Foster/at-risk foster youth, non-engaged TAY are at an elevated risk for mental illness compared to their age peers
- Insufficient preventive programs for TAY
- TAY do not effectively engage in available resources
- Lack of coaching, mentoring or teaching TAY on identifying and developing goals that are directly connected to their passion and motivators.
- Insufficient support resources for at-risk, non-engaged youth and Foster TAY

Information about the progress of this program will be included in the Fiscal Year 2013/14 MHSA Annual Report.

Independent Living Facilities (INN-08)

Expected to begin July 2012, this innovative project will create an Independent Living Facility (ILF) Association with voluntary membership and with the mission of promoting the highest quality home environments for adults with SMI. The ILF Association's mission statement shall include support for the wellness and recovery of all residents. The project is planned to focus on the following key areas:

- Community Collaboration. ILF Association members shall work collaboratively to develop ILF Quality and Ethical standards. Input about the standards shall be solicited from resident clients and their family members. At a minimum, the standards shall identify that the wellness and recovery of resident clients will be supported.
- Creation of an ILF Directory. A web-based listing of participating ILFs shall be created with the purpose of providing a central resource for hospitals, discharge planners, case managers, family members and consumers. The ILF Directory shall identify the facilities adhering to the ILF Quality and Ethical Standards developed.
- Education and Training. Curricula shall be created for:
  - Clients – to assist them in areas, including but not limited to, sustaining independence in the community; adjusting to shared living spaces; developing independent living skills (e.g. nutritious cooking, etc.); communicating with ILF operators; awareness of rights as a resident/tenant.
  - ILF Operators – to be educated on topic areas, including but not limited to, residents with SMI; familiarity with mental health programs; appropriate service standards; differences between ILFs, Board and Care (B&C), and Licensed B&C functions; consultations with case managers or care coordinators; appropriate ILF operator-resident relationships; and skills assisting residents sustain wellness, recovery and independence.

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- Peer Review and Accountability. A Peer Review Accountability Team (PRAT) shall be created to evaluate the implementation of standards and to provide coaching in areas of development. The PRAT may include, at a minimum, a consumer, a family member, and an ILF operator.

This project is expected to create positive impacts for adults particularly in the area of stable housing. Stable housing is an essential initial step in mental health recovery and treatment of mental illness.

Information about the progress of this program will be included in the Fiscal Year 2013/14 MHSA Annual Report.

Health Literacy (INN-09)

This project is currently being reevaluated. An environmental scan will be conducted to see if this project is still relevant as there are several community initiatives currently addressing health literacy.

In-Home Outreach Teams (INN-10)

This innovative program began in January 2012, and is expected to increase family member satisfaction with the mental health system of care, as well as to reduce the effects of untreated mental illness in individuals with SMI and their families.

The In-Home Outreach Teams (IHOT) program is expected to operate up to 3 regional mobile teams that will be clinic-based and provide mobile in-home outreach and engagement services to individuals with SMI and their family members. The IHOT staff, which will include a licensed clinician and a case manager, will provide in-home assessment, crisis intervention, case management and support services to the individuals with SMI and their family or caretaker, as necessary. Peer and family members are integrated in the IHOT teams and they will provide services to include: support services, information and education about mental health services and community resources, linkages to access outpatient mental health care, and other services and resources as needed. A Psychiatric Emergency Response Team clinician will also be available to the regional IHOT teams to link clients for follow up and care coordination of needed services that may include emergency interventions, acute care, alternatives to psychiatric hospitalization such as the Short Term Acute Residential Treatment program, conservatorship and case management services. Additional linkages and coordination with local Emergency Departments, psychiatric hospitals and the legal system, to include the jail system, will be provided, along with programs such as San Diego County Psychiatric Hospital and Emergency Psychiatric Unit. IHOT services will provide flexible in-home services to include 24/7 response with evenings and week-end program hours.

A longitudinal evaluation will be conducted of the IHOT program to determine the success of the outreach and engagement component, client access to outpatient services, retention of clients in outpatient services, reduction of inappropriate utilization of acute care, EDs and jail system. A cost analysis will also be conducted to assess actual costs and savings to the system of care and the community.

Information about the progress of this program will be included in the Fiscal Year 2013/14 MHSA Annual Report.

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Workforce Education and Training

Developing and growing the mental healthcare workforce

The Workforce Education and Training (WET) Plan for San Diego County was approved by the State in July 2009. The plan is focused on increasing the level of linguistically and culturally competent individuals in the public mental health workforce. To address cultural competence issues affecting access to services, an overarching theme that cultural diversity must be incorporated into staff, environment, and service delivery models permeates each training module in the WET Plan. San Diego County's allocation for WET programs is a total of approximately $17 million to be spent by June 30, 2018.

The WET Plan also includes multiple programs developed to enhance the public mental health workforce with emphasis on targeting individuals from linguistically and culturally diverse backgrounds. These programs include the Public Mental Health Credential/Certificate Pathway, Consumer/Family Pathways, School-Based Pathways/Academy, Nursing Partnership for Public Mental Health Professions, Community and Child Psychiatry Fellowships and LCSW/MFT Residency/Intern. These programs all include financial incentives that include stipends, scholarship or loan assumptions to assist individuals from culturally underserved, un-served or underrepresented community affiliations to receive training and/or education for a career or career enhancement in public mental health. All WET funded programs must provide a sustainability plan.

WET Program Highlights for FY 2010/11 include:

- 11 new WET programs
- 2,230 individuals directly impacted
- WET database/outcome tracking
- Member of Southern County Regional Partnership
- Statewide recognition of WET programs

The following are FY 2010/11 highlights for the five funding categories of WET.

Workforce Staffing Support provides funding to plan for, administer, support and/or evaluate the workforce programs and trainings in the remaining four funding categories. This area includes funding for the Workforce Education and Training Coordinator. Special emphasis was placed to assist in the development of the San Diego County WET Collaborative, which initially convened on August 6, 2010. The Collaborative was created in response to a need identified in the San Diego County MHSA WET Plan for creating an ongoing "community voice" for promoting and enhancing a public mental health workforce that is culturally and linguistically representative of the community being served. The collaborative has a diverse group of over forty members representing public mental health systems of care, community stakeholders, consumer and family members, employers/providers and underrepresented community groups. The initial two meetings focused on educating the members about MHSA, the public mental health system and developing initiatives in the public mental health workforce. During the third meeting, which was held on February 4, 2011, members prioritized goals for 2011.

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These four goals will be implemented in four subcommittees of the WET Collaborative and they are Awareness and Attraction; Increasing Diversity; Enhancing Training and Retention; and Sustainability and Community Collaboration.

Training and Technical Assistance consists of events and activities to assist all individuals who provide or support the public mental health system in an improved delivery of services that is consistent with the fundamental principles intended by the MHSA.

The Early Childhood (0 to 5 years) Certificate Program was awarded to San Diego State University Research Foundation and started July 1, 2010. There were 30 students in the program.

In October 2010, Behavioral Health Education and Training Academy (BHETA) designed a free training for consumers and family members/friends who wanted to understand and access the County's mental health system for mental illness and substance abuse assessment, treatment, information and referral options. NAMI San Diego hosted the training which was taught by trained family members and consumers. The goals of the training were the following: 1) The principles that guide services for people with co-occurring conditions; 2) The levels of readiness for recovery; 3) The methods that programs use to determine level of services needed; and 4) How to request appropriate services for the needs of people with co-occurring conditions. Participants learned what specific programs and services are available in San Diego County as well as what to expect from these programs.

Mental Health Career Pathway Programs include educational, training and counseling programs that are designed to recruit and prepare individuals for entry into a career in the Public Mental Health System. Programs address opportunities and equal access for underrepresented racial/ethnic, cultural and/or linguistic groups. Programs also prepare client and family members for employment in the system. This includes strategies for community mental health career pathways beginning in high school, using career development programs and human service academies, and continues through community colleges, adult schools, regional occupation programs, and undergraduate programs.

In July 2010, BHETA became the new provider for Aging Well, a Geriatric Certificate Training program that supports community mental health by providing awareness, knowledge and skills to mental health, aging, primary care and allied professionals on the bio-psychosocial health-related issues and risk factors of older adults and their families/caregivers.

Consumer/Family Pathway included:

- Peer Employment Training – training persons age 18+ to be Peer Specialists with provision of support to become involved in peer specialist work (75 hour course, 80 individuals trained annually)
- Peer Advocacy Training (both brief and intensive curriculums) – training persons age 18+ to be peer advocates with provision of support to become involved in advocacy work (35 hour course, 40 individuals trained annually)
- Funding and support for consumers to attend conferences to promote peer involvement in mental health system (minimum of 20 individuals annually)
- Expanding 'Family to Family' education – for furthering support family education throughout San Diego County, including expanded outreach to underserved communities building off of the NAMI

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Family-to-Family Education Program, a course for family caregivers of individuals with severe mental illnesses, taught by trained family members (10 two hour classes, 40 individuals trained annually)

- Peer Education - Peer training to encourage client awareness of mental illness, coping skills, resource availability, and mutual support possibilities (10 two hour classes, 90 trained annually)
- Youth/Family Employment Training – to help prepare youth and families to work as professional partners. Specific tracks include: Direct Service as a Support Partner, Public Speaking, and Family/Youth Representation (5 day training, 60 trained annually).
- Create a career pathway linked with the Consumer training program so that consumers and family members entering the workforce have avenues to pursue further education, which can lead to higher positions within the public mental health system.

Residency and Internship Programs/School-Based Pathways/Academy are specifically directed to address identified shortages in the licensed, direct service provider positions. Potential programs include: psychiatric residencies, internship programs leading to licensure, and physician assistant programs with a mental health specialty.

The LCSW/MFT Residency/Intern Program is offered at San Diego State University Linguistic and Ethnically Diverse (SDSU LEAD), Alliant International University, and San Ysidro Health Center. This program started on September 1, 2010.

The Public Mental Health Academy program started at the San Diego Community College – City Campus on October 1, 2010 and at Alliant International University on November 1, 2010.

Health Sciences High School and Middle College is a public charter high school that provides students an opportunity to explore advances and opportunities in healthcare through its college preparatory curriculum, specialized electives and four-year work-based internship program. Located in City Heights, one of San Diego's most linguistically, culturally and economically diverse urban communities, where over 60% of the students live at or below the poverty line and qualify for free and reduced lunch, over 50% of the students' first language is not English and 75% of the students are non-white, including 45% Hispanic and 20% African American. This program creates a specialized mental health worker career track that serves 50 students per year in a two-year certificate program. In addition, curriculum and specialized activities will be offered school-wide in order to teach all 500 students to take steps to end the stigma associated with mental illness and its manifestations, to know more about seeking services for their own needs and, to consider this area of development as part of their own career exploration. Students will also receive a stipend for completing an internship in mental health. This program began its mental health pathway in September 2010 and is already having a dramatic impact on the future of the youth. Zachery (aka Heath) Felix, 17 years old, wrote the following about his experience:

> *"My experience with the mental health grant has been extraordinary, shaping my future in ways I have never imagined. In my first year with it, I spent my time with Sharp Mesa Vista, Sharp's leading mental health facility. I had the privilege to work often with the Older Adult Program and make a difference in the geriatric community. From there I moved to observing Marriage and Family counseling sessions through a program with SDSU's community outreach program. This experience changed my entire view on mental health and put me on the path to applying to UCSD in Psychology. I have been accepted and will be attending in the fall. Finally, I moved to working with San Diego*

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Youth Services adoption program, which has been one of the most amazing experiences I have had with this grant. I have realized that mental health is not the stereotype of caring for 'crazy people,' but to help anyone and everyone in having a full, rich life, one free of the hardships that a heavy mind and soul would give. This grant has done amazing things for me and changed the course of my life."

Alfredo Aguirre and Health Sciences High School and Middle College students

Financial Incentive Programs have been incorporated into the LCSW/MFT Residency/Intern, the Public Mental Health Academy, the School-Based Pathway and the Nursing Partnership programs. Objectives include:

- Increase the recruitment and retention of qualified candidates who may have already completed their studies in exchange for commitment to work in public mental health workforce.
- Increase the number of licensed professionals committed to working in the public mental health system.
- Increase the ethnic diversity of these licensed professionals.
- Increase the number of employees from underserved backgrounds.
- Increase the number of employees with critical linguistic proficiencies.
- Provide advanced educational and employment opportunities to individuals with experience as consumers and family members.
- Ensure that prospective and current employees who have received incentives remain employed in the County's public mental health system for up to 2 years.
- Offer approximately $360,950 annually in financial incentives (stipends/scholarships) to attract and retain qualified job candidates.
- Award incentives to numerous individuals annually, depending on the dollar amount of each grant.
- Increase collaboration between the public mental health system and local graduate programs in the mental health professions.

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Capital Facilities and Technological Needs

Improving the infrastructure of California's mental health system

A portion of MHSA funding was specifically set aside for the fifth component, Capital Facilities and Technological Needs, to promote the efficient implementation of the MHSA. The planned use for these funds will produce long-term impacts with lasting benefits that move the mental health system towards the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families which promote reduction in disparities to underserved groups.

Capital Facilities and Technological Needs Component (CFTN) is a unique MHSA component as it incorporates funding for two primary projects: 1) Capital Facilities and 2) Technological Needs. The total one-time funding available to the County of San Diego for this component is $37,346,700. The County of San Diego Mental Health Services proposed a 35%/65% distribution of funds between capital facilities and technological needs, respectively, and the proposal was subsequently approved in principle by the DMH on April 2, 2009. The distribution is subject to change based on the ongoing community input process. The CFTN component will help prepare the County of San Diego for healthcare reform activities at the state and federal levels, which include a much greater use of technology to assist with disease management, consumer self-sufficiency, and the transfer of data seamlessly among providers.

Capital Facilities

The County's use of Capital Facilities funds is expected to move the local mental health system toward the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families. To further the integration goals of *Live Well, San Diego!*, Capital Facilities funds will be used to support a consumer integrated health experience offering mental and other human health services.

In June 2010, County Mental Health Services conducted surveys and held four countywide public forums in an effort to identify the capital facilities needs of mental health clients, consumers, stakeholders and the general public.

The Capital Facilities projects include:

1. The purchase of a permanent pre-fabricated building to house the Stabilization, Assessment, Transition Team (STAT) that work in conjunction with the County Probation Department to provide services to court-ordered adolescents with mental health needs at Juvenile Hall;
2. Proposed partial demolition of an older County-owned facility in the North Coastal Region and replacement with a new, larger facility to house mental health and other human services, including rehabilitation, wellness and skill development;
3. Proposed purchase and major renovation of an existing facility in the Central Region that will house a multi-service program for transition age-youth (TAY ages 16-24), including wellness,

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rehabilitation, skill development, vocational and other human services. There will be collaboration and potential co-location with other HHSA TAY services including foster youth; and,

4. HHSA has identified the southeast location of the Central region as a potential project target for full integrated health and social services.

Technological Needs

In an effort to identify the technological needs of mental health clients, consumers, stakeholders and the general public, County Mental Health Services conducted two county-wide surveys, with 1,329 respondents. Additionally, there were three regional forums conducted, and four focus groups met under the joint auspices of the Family Youth Roundtable, an independent family- and youth-led organization, and Recovery Innovations of California, a client-operated peer support service.

San Diego County Mental Health Services will be proposing several possible technology projects which will address two MHSA goals:

1. Increase Client and Family Empowerment and engagement by providing the tools for secure client and family access to health information that is culturally and linguistically competent within a wide variety of public and private settings.
2. Modernize and Transform clinical and administrative information systems to ensure quality of care, parity, operational efficiency and cost effectiveness.

With start-up funding provided by the MHSA under the Community Services and Supports component, the Technological Needs Mental Health Management Information System (MIS) project plan was approved by the State August 2010. The implementation phase is expected to be complete June 30, 2012.

In addition to the MIS project, the following 7 Technological Needs Projects were approved by the State May 2011.

- Consumer/Family Empowerment (SD-2) - Employs multiple projects to make available resources and tools for secure client and family access to health information that is culturally and linguistically competent through appropriate public and private settings.
- Personal Health Record (SD-3) – Implementing the Personal Health Record (PHR) to all Mental Health System of Care providers for clients and family members. A PHR is an individual client health record controlled by the client.
- Appointment Reminder (SD-4) – The Outbound Dialer system will be utilized, with client's permission, by clinics to telephone consumers with appointment reminders.
- Telemedicine Expansion (SD-5) – Expand the utilization of Telemedicine video conferencing technology for up to twenty sites. The technology will allow a trained psychiatric professional to communicate with consumers in need of urgent psychiatric consultation/evaluation
- MIS Enhancements (SD-6) – Expansion of MIS to include Document Management, Doctor's Home Page and Signature Pads. Document Management provides all Mental Health System of Care providers with the ability to electronically scan and store client documents. Doctor's Home Page allows doctors to prescribe medications quickly and instantly update client treatment plans. Signature Pads are devices that will allow clients to have the ability to sign electronically.

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- SpeEd Link (SD-7) – A project that has been reevaluated due to the transition of services under Educationally Related Mental Health Services.
- Data Exchange Pilot (SD-8) – Linking behavioral health data with primary care health information to build an integrated community health record for clients seen at a community health center or county-contracted program.

Information about the progress of these projects will be included in the Fiscal Year 2013/14 MHSA Annual Report.

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FISCAL YEAR 2012-2013 EXPENDITURE PLAN

Due to contract under spending allocated budgets and initial slow start as a result of a long procurement process, an additional $11,000,000 of funding is being incorporated into selected CSS and PEI programs. This amount includes funding to sustain the programs that were enhanced in Fiscal Year 11/12. The programs below are enhancements proposed for Fiscal Year 12/13. The Fiscal Year 12/13 budgets are included in Appendix C.

Community Services and Supports

Full Service Partnership for Children and Youth (CY-FSP)

ADS COUNSELORS - $600,000

Enhance Medi-Cal capacity in CMH Clinics to increase access to services and decrease wait times. Advance Behavioral Health Integration through addition of alcohol and drug counselors (ADS) to provide supplemental services to address substance abuse/use issues. Programs will serve a minimum of 500 unduplicated clients per fiscal year. ADS Counselors will further the BHS integration and create greater awareness, screening and treatment of those clients and families with co-occurring disorders or present a heightened risk in substance use domain.

Full Service Partnership for Ages 18 through 65+ (TAOA-FSP)

EXPANSION OF FSP - $2,100,000

Increase the number of FSP slots and provision of ACT services for 50 additional homeless clients in downtown area, 50 additional individuals leaving IMDs, 25 additional individuals leaving the justice system and 25 additional homeless TAY.

System Development for All Age Groups (ALL-SD)

PSYCHIATRIC EMERGENCY RESPONSE TEAM (PERT) TRAINING - $25,000

Increase PERT training capacity by 75 members of the safety sector.

CHALDEAN SERVICES - $75,000

Adding 0.5 FTE clinical staff as well as administrative oversight. Increase clinical services to a minimum of 18 additional refugee children/youth in school based setting.

System Development for Children and Youth (CY-SD)

TREATMENT AND EVAULATION RESOURCES MANAGEMENT - $325,000

Provide for development and monitoring of clinical standards for parent group curriculums, provide quality management oversight of parent group therapy for parents referred through Child Welfare Services (CWS).

FOSTER YOUTH/TAY IN INDEPENDENT LIVING - $500,000

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Provide intensive case management and housing for 70 non-dependent foster youth. Funds are leveraged with CWS.

TRAUMA FOCUSED COGNATIVE BEHAVIORAL THERAPY (CBT) TRAINING - $125,000

Train a minimum of 100 clinicians per fiscal year in Trauma Focused CBT which is an evidence-based model deemed highly effective with Children's Mental Health Services target population. Special attention to trauma informed care is being infused throughout the County system.

FOSTER YOUTH IN NORTH REGIONS - $405,000

Expand collaborative program with CWS to North Regions. Services integrate CWS best practices of family visitation including meal and evidence-based parent groups using Incredible Years Program. Children receive individual mental health services.

COOL BEDS - $250,000

Provide crisis services through establishments of two "cool beds" for youth requiring brief crisis stay to avert acute hospital care.

System Development for Ages 18 through 65+ (TAOA-SD)

OUTPATIENT MENTAL HEALTH RECOVERY SERVICES - $1,032,807

Increase to 1.0 FTE clinician and 0.5 FTE administrative staff and add medical doctor outpatient hours to enhance rehabilitation and recovery services to 4 outpatient mental health recovery programs for 149 unduplicated clients in North Coastal and 149 unduplicated clients in North Inland. Additional funds to cover increase in lease amount. Extensive outreach in the community, increased engagement and developmentally appropriate services to an additional 131 unduplicated TAY clients.

SUPPORTED EMPLOYMENT - $125,000

Develop employment capacity for individuals with SMI in the business sector to further develop supported employment throughout the County.

CLIENT OPERATED PEER SUPPORT SERVICES - $10,000

Funding for a consumer educational event.

CLUBHOUSE ENHANCEMENT - $35,000

Adding Food Service Manager and Job Developer to provide enhanced health, nutrition, and job development services as membership daily attendance has risen to 70 members attending daily.

SHORT TERM ACCUTE RESIDENTIAL TREATMENT PROGRAM - $200,000

Increase hours of medical doctor face to face coverage for six Short Term Acute Residential Treatment (START) programs which provide enhanced psychiatric services by psychiatrists who are specifically aligned with psychosocial rehabilitation and recovery philosophy, and maintain services for current client caseloads.

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Prevention and Early Intervention

Primary & Secondary Prevention: Public Outreach, Education and Support Lines (PS-01)

STUDENT PROJECT - $100,000

An anti-stigma conference developed by high school students for high school students; senior students from the mental health pathway program will be provided with an internship and supervision to develop and implement the conference for 100 high school students.

IN-REACH TO INCARERATED AFRICAN AMERICAN AND LATINO POPULATION - $350,000

Enhancement to cover the costs of 1.0 FTE licensed clinicians, 2.0 FTE case managers, and 2.0 FTE peer staff to in-reach to Central Jail, Vista Detention Facility, and Las Colinas to 400 African American and Latino at-risk individuals to assess for educational, vocational, counseling, substance abuse, medical and other needs; engage and link to relevant services to improve life satisfaction and reduce recidivism and possible SMI.

HELPLINE EXPANSION - $50,000

Facilitate public education by trained consumer speakers who discuss their experience with mental illness and achieving recovery with 200 presentations to be provided to at least 4,000 people Countywide.

MENTAL HEALTH 1ST AID - $500,000

Addition of 6.0 FTE non-clinical instructors and 3.0 FTE administrative staff to coordinate 12-hour classes teaching mental health signs and symptoms to non professionals to de-stigmatize mental health and prepare them to encourage friends and family members to seek help when needed. Presentations to be provided to at least 5,000 people countywide.

CLUBHOUSE FOR THE DEAF OR HARD OF HEARING - $133,839

Establishing clubhouse for 50 at-risk deaf or hard of hearing TAY and adults. The clubhouse will offer skill development for deaf youth aging out of the deaf group home. There will be meaningful structure/activities for at-risk deaf individuals who do not have other opportunities for employment and other life supports. This would be an opportunity to offer health and wellness education and activities to the deaf community as well as jobs to deaf individuals who are non-professionals.

FAMILY ENGAGEMENT IN PSYCHIATRIC HOSPITALS - $75,000

Addition of 1.0 FTE Coordinator to help facilitate outreach and of family members who have lived experience to 500 people visiting their loved ones in psychiatric hospitals. Establish table in lobby during visiting hours of most or all fee-for-service psychiatric hospitals for coordinator to provide emotional support, information and hope to people visiting their loved ones.

PARENTING GROUPS FOR AFRICAN AMERICAN FATHERS/CAREGIVERS - $150,000

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Through community collaboration, a need to support African American fathers and caregivers in the Southeast community has been identified. Evidence based or best practice models shall be used to provide multiple parenting groups, targeting a minimum of 75 children/youth.

South Region Trauma Exposed Services (DV-02)

TRAINING PROGRAM FOR 0 TO 5 POPULATION - $100,000

Enhancement will result in increased practicum placements where early intervention services are provided directly to children in low income day centers. Augmented capacity will allow for more direct services to children, their parents as well as day care staff. Increase enrollment from 30 to 40 students in this unique post bachelors training certificate for those working with the 0 to 5 population with an emphasis on early intervention and prevention through a solid early childhood foundation grounded in age appropriate developmental and social/emotional well being. Enhance the post masters training curriculum to meet standards for Infant-Family and Early Childhood Mental Health Competency Training Guidelines from 2010.

Alliance for Community Empowerment (DV-03)

CLINICIAN - $120,000

Enhance program with a clinician to provide brief crisis services, evaluation of behavioral health needs and referral/linkage to Behavioral Health treatment with families/community impacted by violence.

Kick Start (FB-01)

EXPAND SERVICES TO 32 ADDITIONAL INDIVIDUALS - $325,000

Intensive services to 32 additional individuals ages 12-24 who are experiencing at-risk or high risk behaviors or features of a "first break", or psychotic episode. Services to include evaluation/assessment, peer support and mentoring, family psycho-education, educational and employment support services, comprehensive mental health treatment, as well as information and linkages to extended treatment as needed.

Elder Multicultural Access and Support Services (OA-01)

INCREASE STAFF AND OUTREACH TO CHALDEAN/MIDDLE EASTERN SENIORS - $125,000

Increase staffing by 0.75 FTE Promotora and expand program to include health and wellness education, to 75 Chaldean/Middle Eastern seniors in the East County region. Enhancement will also help with meeting/office space.

Positive Solutions (OA-02)

INCREASE STAFF AND OUTREACH TO HOMEBOUND ASIAN/PACIFIC ISLANDER SENIORS - $125,000

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Increase staffing by 0.5 FTE counselor to outreach to 50 homebound seniors including Asian/Pacific Islanders in the North Central Region.

REACHing Out (OA-04)

INCREASE STAFF AND OUTREACH TO SENIORS IN SOUTH REGION - $80,000

Increase Promotora staff by 2.0 FTE to provide early intervention psycho-educational services to 100 additional Older Adults in the South Region.

CASE MANAGEMENT - $100,000

Adding case management services for seniors with cognitive decline/depression/anxiety.

Salud (OA-05)

INCREASE STAFF, OUTREACH TO SENIORS AND DATA COLLECTION - $150,000

Increase staff and provide outreach services to an additional 110 unduplicated individuals and provide Diabetes Self-Management workshops to an additional 56 unduplicated individuals. Increase staff to perform data collection/analysis for evaluation component.

SmartCare (RC-01)

EXPAND RURAL INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE SERVICE - $150,000

Expand program to provide clinical and psychiatric consultation and resources, referral services to primary care providers. Outreach; consultants will conduct engagement, and psycho-educational groups.

School-Based Program (SA-01)

EXPAND TO ADDITIONAL SCHOOLS - $300,000

Expand program to additional schools in North and East Regions to include Family Community Outreach Specialists and school based services.

Co-Occurring Disorder – Screening by Community-Based Alcohol Drug & Services Providers (CO-02)

BEHAVIORAL HEALTH INTEGRATION - $492,000

Adding clinicians to provide mental health screening and assessment, individual and group counseling, and linkage to specialist mental health services to clients with dual disorders for TAY and adults.

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FISCAL INFORMATION

See Appendix C for the Fiscal Year 2012/13 Budget as well as a breakdown of the Enhancements.

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APPENDIX A – FULL SERVICE PARTNERSHIP OUTCOMES REPORT

Included in this section are the following reports:

1. Full Service Partnership Report for Adult/Older Adults
2. Full Service Partnership Lite Report for Adult/Older Adults
3. Full Service Partnership Report for Children
4. Full Service Partnership Lite Report for Children
5. Peer Support Specialist Report

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Full Service Partnerships
OUTCOMES REPORT

FSP Programs
April, 2012

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Making a Difference in the Lives of Adults & Older Adults with SMI

San Diego County Full Service Partnership (FSP) Programs promote recovery and resilience through comprehensive, integrated, consumer-driven, strength-based care and a "whatever it takes" approach. Targeted to help those clients with the most serious mental health needs, services are intensive, highly individualized, and focused on helping clients achieve long-lasting success and independence.

Full fidelity assertive community treatment teams—which include psychiatrists, nurses, mental health professionals, employment specialists, peer specialists, and substance-abuse specialists—provide medication management, vocational services, substance abuse services, and other services to help consumers sustain the highest level of functioning while remaining in the community.

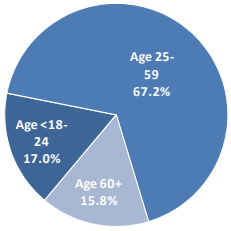
Clients receive services in their homes, at their workplace, or in other settings in the community they identify as the most beneficial to them or where support is most needed. Crisis intervention services are available 24 hours a day, 7 days a week.

In this report we use a variety of data sources to examine recovery outcomes for FSP clients during Fiscal Year 2010-2011, focusing on changes in clients':

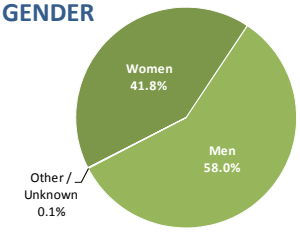
- Housing, employment, education, and access to medical care from the time of FSP enrollment (intake) to the time of their most recent assessment during FY10-11 (latest);
- Use of inpatient and emergency services and placements in restrictive and acute medical settings;
- Scores on clinician and client self-reported recovery measures;
- Progress toward key treatment goals.

1,716 Clients Served in FY10-11 — Demographics & Diagnoses

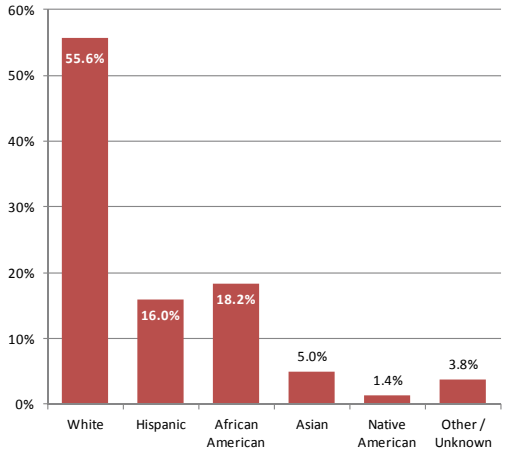
AGE



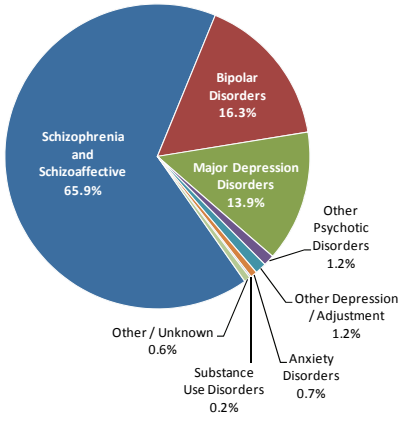
GENDER



RACE / ETHNICITY



PRIMARY MENTAL HEALTH DIAGNOSIS

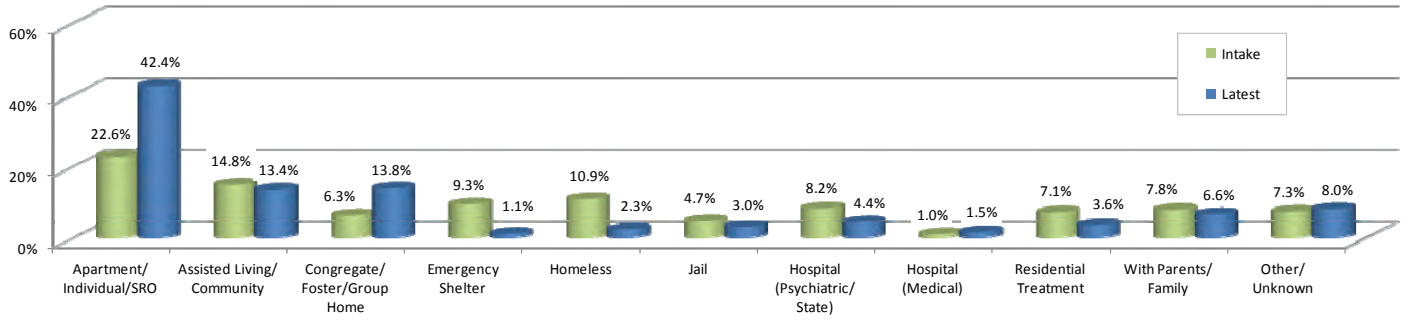


Data source: Anasazi 10/2011 download

MEETING FSP CLIENTS' BASIC NEEDS

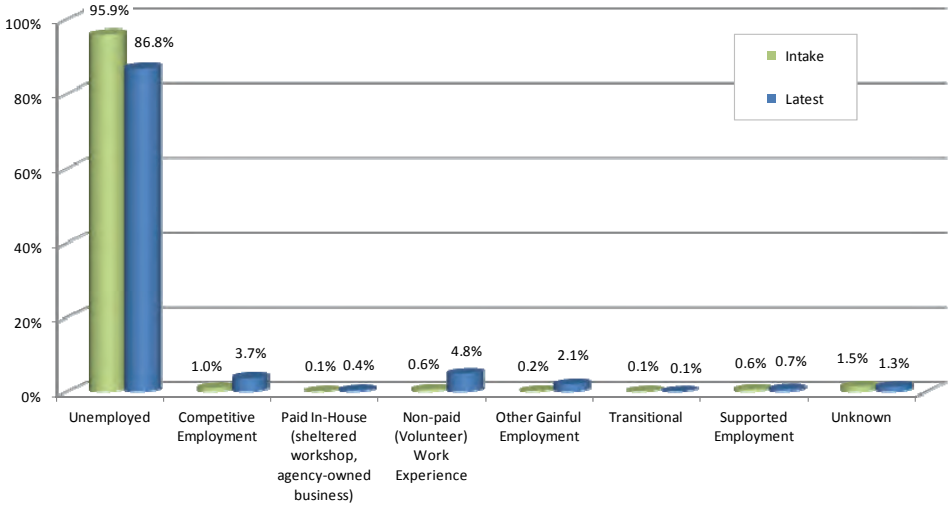
In Fiscal Year 2010-2011, FSP clients showed improvement in many areas of basic needs. Significant improvements were seen in movement of people from homelessness (10.9% at intake vs. 2.3% latest) and emergency shelter (9.3% at intake vs. 1.1% latest) into better living arrangements. Significantly larger percentages of clients were able to secure more adequate housing: 42.4% in an apartment or individual living situation and 13.8% in congregate/foster or group homes. About half as many clients were in psychiatric hospital settings (8.2% at intake vs. 4.4% latest).

HOUSING



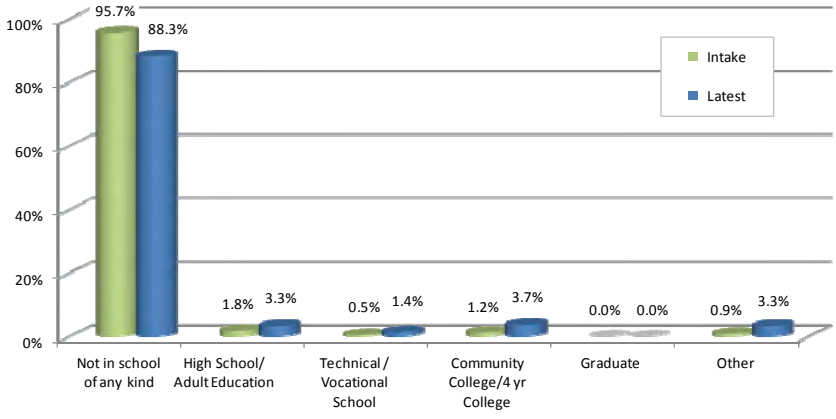
For some clients, involvement in meaningful occupational activities is an important part of recovery. FSPs can help connect clients to a variety of employment opportunities ranging from volunteer work experience to supported employment in sheltered workshops, to competitive, paid work. While most clients remained unemployed (86.8%), there was an improvement from intake to latest assessment with some clients moving from unemployed to other occupational statuses. The biggest gains were seen in movement into non-paid (volunteer) work experience (from 0.6% to 4.8%) and competitive employment (from 1% to 3.7%).

EMPLOYMENT



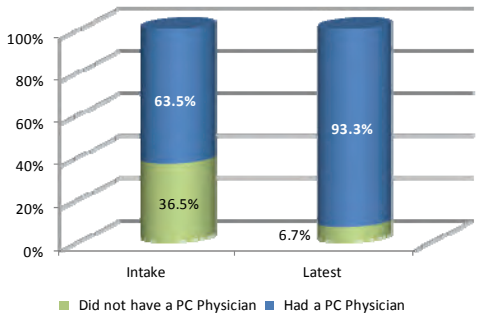
A number of FSP clients became more involved with educational activities, although this is not a goal for all. At intake, 4.4% of clients were enrolled in educational settings vs. 11.7% at the latest assessment.

EDUCATION



At intake, 63.5% of clients reported having access to a primary care physician. In contrast, 93.3% of clients reported having a primary care physician at follow up.

CLIENTS WITH A PRIMARY CARE PHYSICIAN



Data source for all charts on this page: California Department of Mental Health Data Collection and Reporting System (DCR) 9/15/11 download; (N=1,562); Education data missing for 34 (intake) 31 (latest) clients.

CHANGES IN SERVICE USE & SETTING

FSP programs appear to decrease the use of expensive inpatient and emergency services such as Emergency Psychiatric Units (EPU), Psychiatric Emergency Teams (PERT), crisis residential, and inpatient psychiatric hospital services. Overall, use of these services declined by 7% as measured by mean number of services used, and by 39.3% when considering the number of clients using services. An increase in the number of mean services in inpatient psychiatric (14.5%) among fewer clients (29.9%) may indicate that inpatient psychiatric services were being deployed at a higher level of intensity to a smaller, more targeted population of clients most in need of those services. The same pattern, though to a lesser extent, was observed for use of PERT. Use of EPU and crisis residential services both decreased in terms of average number of services used and number of

USE OF INPATIENT & EMERGENCY SERVICES (PRE/POST)

	12 MONTHS PRIOR TO FSP ENROLLMENT (PRE)		FISCAL YEAR 10-11 (POST)		% CHANGE PRE/POST		MEAN # SERVICES PER CLIENT AMONG USERS		% CLIENTS	
EMERGENCY SERVICE TYPE	# SERVICES	# CLIENTS	# SERVICES	# CLIENTS	MEAN # SERVICES	# CLIENTS	PRE	POST	PRE	POST
EPU	1,042	403	374	153	-5.5%	-62.0%	2.6	2.4	34.2%	13.0%
PERT	286	186	255	163	1.7%	-12.4%	1.5	1.6	15.8%	13.8%
Crisis Residential	436	245	173	112	-13.2%	-54.3%	1.8	1.5	20.8%	9.5%
Psychiatric Hospital	811	321	651	225	14.5%	-29.9%	2.5	2.9	27.3%	19.1%
Overall	**2,575**	**598***	**1,453**	**363***	**-7.0%**	**-39.3%**	**4.3**	**4.0**	**50.8%**	**30.8%**

Data source: Anasazi 10/2011 and InSyst 10/2008 downloads; California Department of Mental Health Data Collection and Reporting System (DCR) 9/15/2011 download used to identify active clients.

*The overall numbers of clients pre (598) and post (363) indicate unique clients, many of whom used multiple, various services, whereas some clients used no emergency services.

Clients in this analysis (1,177): had an enrollment date <= 7/1/2010 and discontinued date (if inactive) > 7/1/2010.

FSPs strive to help clients work toward recovery while remaining in the community. In FY10-11, there was an overall decrease in both mean number of days spent and the number of clients in restrictive settings: jail/prison, state hospital, and long-term care. The data on placement in acute medical settings are considered separately in the table below because medical hospital stays are probably best understood to represent an increase in care coordination and access to care.

- Both the mean number of days clients spent in jail or prison, and the number clients who were incarcerated, decreased (by 36.4% and 46.9%, respectively).
- Placement in state hospital also decreased, with the mean number of days reduced by 42.6% and the number of clients down by 73.3%.
- The mean number of days clients spent in long term care increased by 10.7%, while the number of clients being placed in long term care decreased by 53.7%. This suggests that fewer clients required long term care but those who did receive long term placement required slightly longer stays.
- Both the mean number of days and number of clients in acute medical settings increased (by 141.5% and 61.5%, respectively), suggesting that clients' access to medical treatment increased after FSP enrollment.

PLACEMENTS IN RESTRICTIVE & ACUTE MEDICAL SETTINGS (PRE/POST)

	12 MONTHS PRIOR TO FSP ENROLLMENT (PRE)		FISCAL YEAR 10-11 (POST)		% CHANGE PRE/POST		MEAN # DAYS PER CLIENT AMONG USERS		% CLIENTS	
TYPE OF SETTING	# DAYS	# CLIENTS	# DAYS	# CLIENTS	MEAN # DAYS	# CLIENTS	PRE	POST	PRE	POST
Jail/Prison	17,271	179	5,829	95	-36.4%	-46.9%	96.5	61.4	17.1%	9.1%
State Hospital	2,705	30	414	8	-42.6%	-73.3%	90.2	51.8	2.9%	0.8%
Long-Term Care	11,889	67	6,089	31	10.7%	-53.7%	177.4	196.4	6.4%	3.0%
Overall	**31,865**	**260***	**12,332**	**128***	**-21.4%**	**-50.8%**	**122.6**	**96.3**	**24.8%**	**12.2%**
Medical Hospital	897	78	3,500	126	141.5%	61.5%	11.5	27.8	7.4%	12.0%

Data source: California Department of Mental Health Data Collection and Reporting System (DCR) 9/15/2011 download; 12 month pre-enrollment DCR data rely on client self-report.

Clients in this analysis (N=1,047): had an Enrollment date <= 7/1/2010 and Discontinued date (if inactive) > 7/1/2011; Clients had to be active throughout the FY to be included.

*The overall numbers of clients pre (260) and post (128) indicate unique clients, many of whom used multiple, various services, whereas some clients used no services.

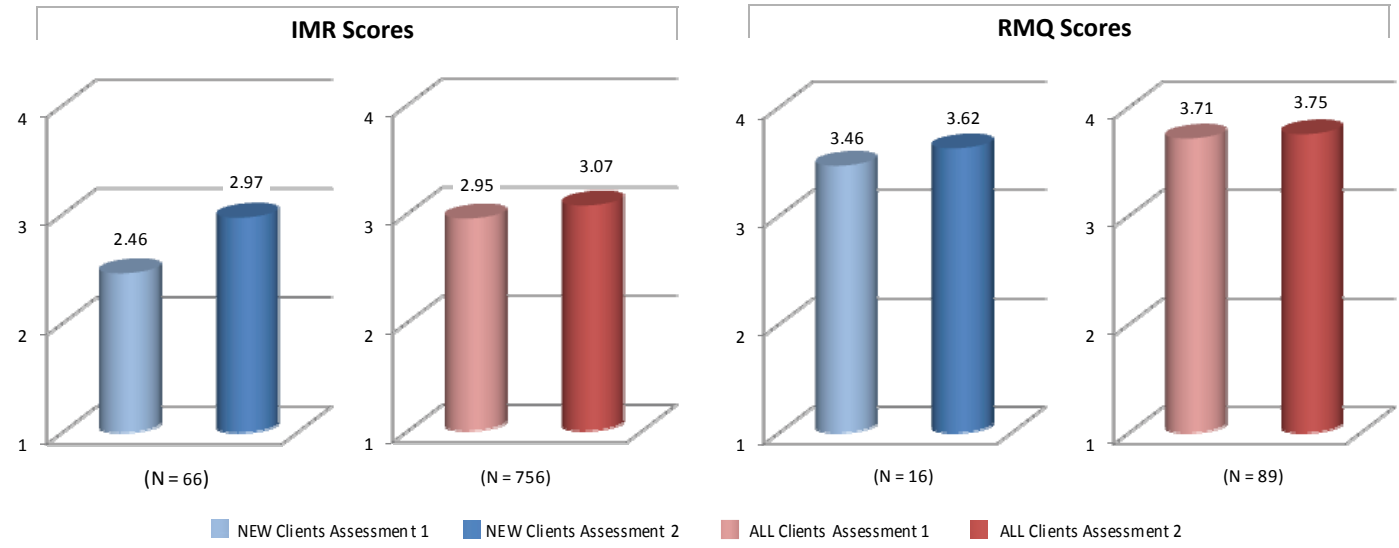
MEASURING PROGRESS TOWARDS RECOVERY

Comparing NEW and ALL FSP Program Clients

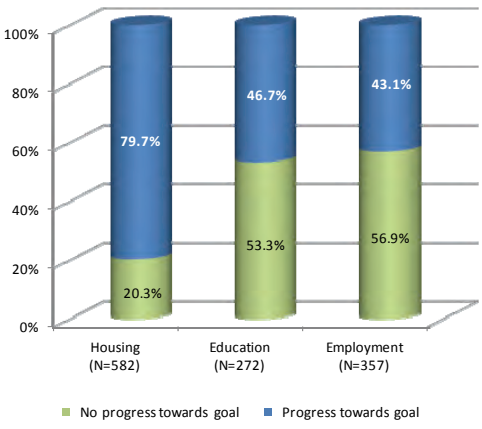
FSP clients' progress toward recovery is measured using two different instruments—the Illness Management and Recovery Scale (IMR) and the Recovery Markers Questionnaire (RMQ). Clinicians use the IMR scale to rate their clients' progress towards recovery. The IMR has 15 individually scored items; scores can also be represented using subscales or overall scores. Clients use the 24 item RMQ scale to rate their own progress towards recovery. Higher ratings on both the IMR and the RMQ indicate greater recovery. Scores range from 1-5.

The FSP client scores displayed in the charts below compare scores of "New Clients" to those of "All Clients." New clients are those who started receiving services in 2010 or later and whose first service date was within 30 days of their first IMR assessment; All Clients includes every client who had both a baseline and follow up IMR assessment, regardless of how long they have received services. Scores for New clients more directly demonstrate the effect of FSP services on client outcomes because All clients includes those people who may have been receiving services for long periods of time, starting before the implementation of FSP programming.

IMR and RMQ Scores increased for both New and All clients. New clients' IMR scores at intake were lower than All clients' scores but New clients achieved much greater gains between intake and latest assessment. Both New and All clients' RMQ scores were higher than their IMR scores, indicating that both New and All clients tend to rate their progress higher than do clinicians. RMQ scores for New clients showed more progress than RMQ scores for All clients.



MAKING PROGRESS TOWARDS KEY TREATMENT GOALS



All FSP Clients Whose Treatment Plan Includes Key Progress Goals — Progress at Latest IMR Assessment

In their IMR assessments, clinicians also note client progress toward goals related to housing, education, and employment. The chart on the left illustrates progress made by those FSP clients whose treatment plan included one or more of these key goals.

Of those FSP clients with a housing goal on their treatment plan, 79.7% demonstrated progress toward the goal, while 20.3% did not. Of those with an education goal on their treatment plan, 46.7% demonstrated progress, while 53.3% did not demonstrate progress. And of those clients with an employment goal on their treatment plan, 43.1% demonstrated progress toward the goal, while 56.9% did not. Both education and employment are longer-term goals than housing.

Data source for all charts on this page: HOMS FY10-11; Data include all HOMS entries as of 4/5/2012 for clients active in all FSP Programs during FY10-11 and who had paired IMR/RMQ assessments within 6 months.

Full Service Partnership-Lites OUTCOMES REPORT

FSP-Lite Programs
April, 2012

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Making a Difference in the Lives of Adults & Older Adults with SMI

San Diego County Full Service Partnership Lite (FSP-Lite) Programs provide a diverse array of case management and outpatient programs. While offering fewer comprehensive services than FSP programs, they share the same focus on rehabilitation, recovery, and community integration. The goal of the programs is to build on client strengths and assist in the development of abilities and skills that allow clients to become and remain successful in the community, while avoiding the need for more intensive mental health services.

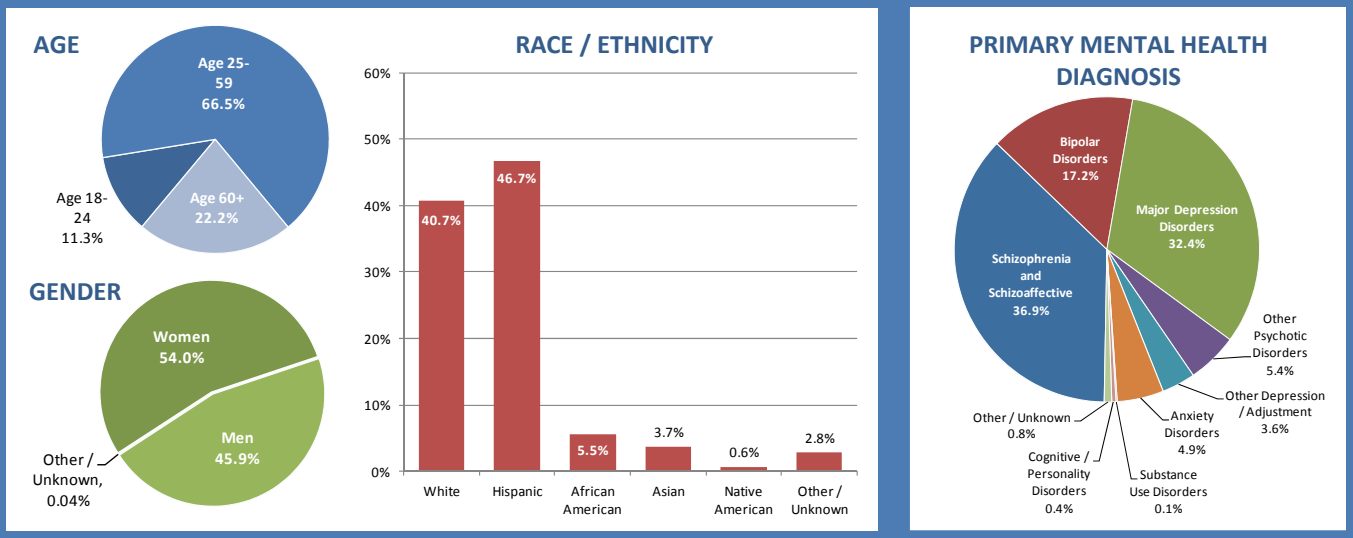
Services offered by most FSP-Lite programs include psychosocial assessments, mental health and substance abuse screening, medication support, individual and group counseling, intensive case management, crisis intervention, care coordination, employment services, and outreach. Some FSP-Lite programs tailor services to selected populations, such as older adults or transition age youth, and some offer specialized services, such as in-home psychotherapy, peer counseling, and neuropsychological assessment.

FSP-Lite program staff are multidisciplinary and generally include psychologists, marriage and family therapists, psychiatrists, nurses, social workers, case managers, peer specialists, rehabilitation counselors and master's level psychology interns.

In this report we use a variety of data sources to examine recovery outcomes for FSP-Lite clients during Fiscal Year 2010-2011, focusing on changes in clients':

- Housing, employment, education, and access to medical care from the time of FSP-Lite enrollment (intake) to the time of their latest assessment during FY10-11;
- Use of inpatient and emergency services and placements in restrictive and acute medical settings;
- Scores on clinician and client self-reported recovery measures;
- Progress toward key treatment goals.

2,275 Clients Served in FY10-11 — Demographics & Diagnoses

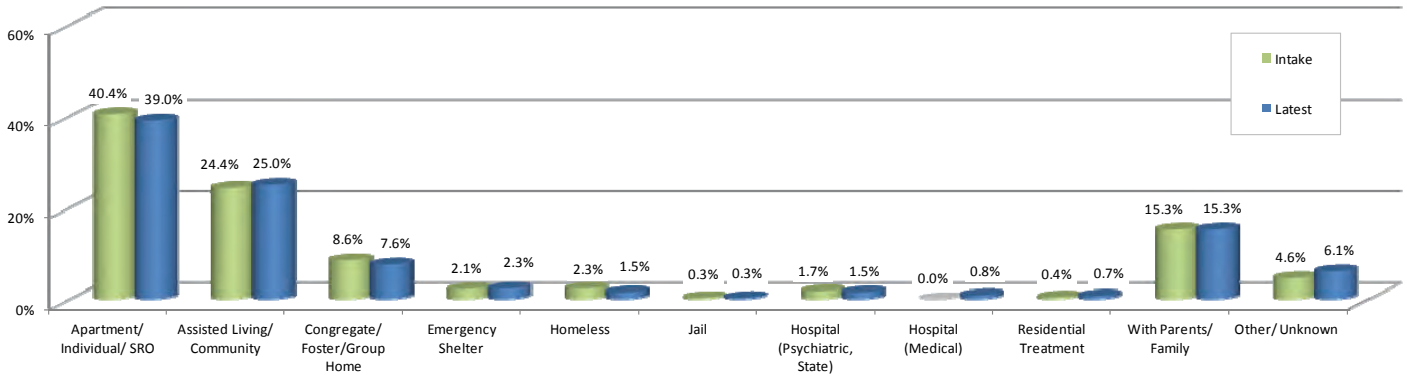


Data source: Anasazi 10/2011 download

MEETING FSP-LITE CLIENTS' BASIC NEEDS

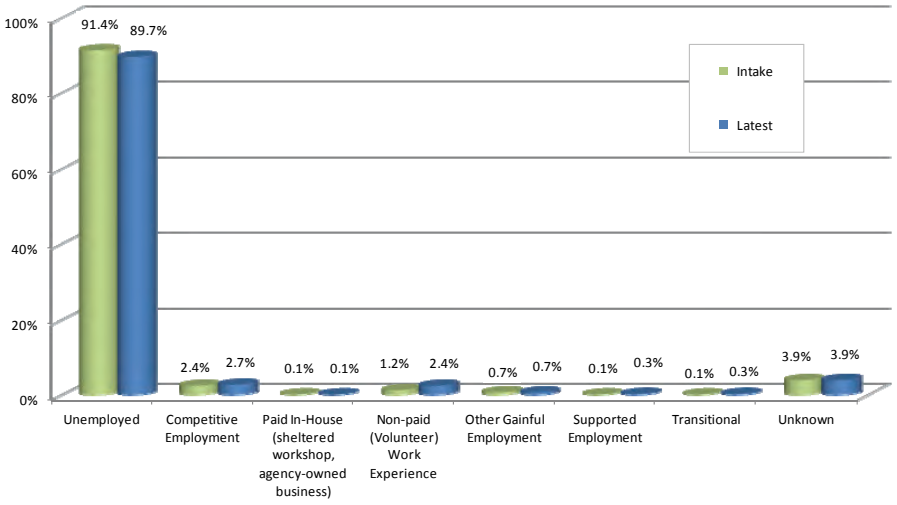
In Fiscal Year 2010-2011, clients showed slight gains between intake and latest assessment in some areas of basic needs. Data on clients' residential status show that there were slight decreases in homelessness (2.3% vs. 1.5%) and residence in psychiatric and state hospitals (1.7% vs. 1.5%). There was a slight increase in assisted living in the community (from 24.4% to 25%) and no change in numbers of clients living with parents/family. Clients residing in emergency shelters increased slightly (from 2.1% to 2.3%) while the numbers of clients living independently in apartments or SROs decreased from 40.4% to 39%.

HOUSING



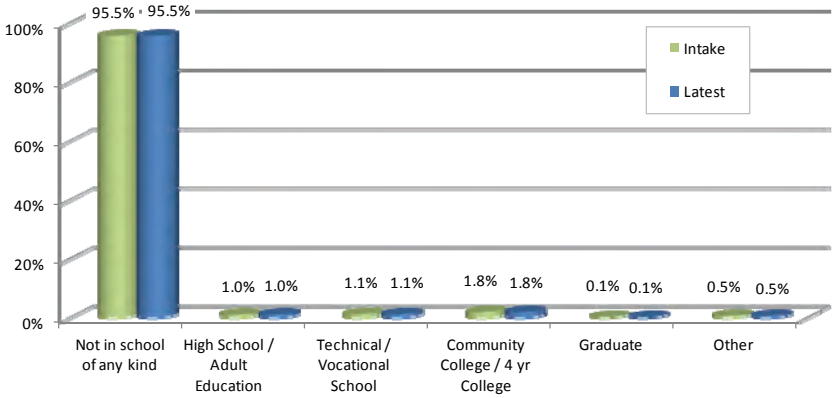
EMPLOYMENT

For some clients, involvement in meaningful occupational activities is an important part of recovery. FSP-Lites can help connect clients to a variety of employment opportunities ranging from volunteer work experience to supported employment in sheltered workshops, to competitive, paid work. While most clients remained unemployed (89.7%), there was some improvement from intake to latest assessment with clients moving from unemployed to other occupational statuses. The biggest gains were seen in movement into non-paid (volunteer) work experience (1.2% to 2.4%) and competitive employment (from 2.4% to 2.7%).



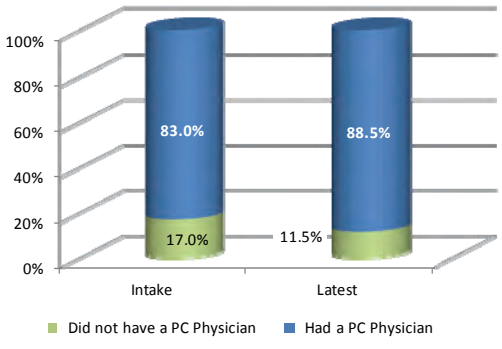
Education is not a goal for most FSP-Lite clients. Involvement in educational activities remained the same for all education categories (1 client who had not been enrolled in school entered community college and another who had been in community college left school).

EDUCATION



Client access to primary care increased slightly, with 83% of clients reporting at intake they had a primary care physician vs. 88.5% reporting access to a primary care physician at follow up.

CLIENTS WITH A PRIMARY CARE PHYSICIAN



Data source for all charts on this page: CA Department of Mental Health Data Collection and Reporting System (DCR) 9/15/11 download; (N=747); Education data missing for 19 clients.

CHANGES IN SERVICE USE & SETTING

FSP-Lite programs appear to decrease the use of expensive inpatient and emergency services such as Emergency Psychiatric Units (EPU), Psychiatric Emergency Teams (PERT), crisis residential, and inpatient psychiatric hospital services. Overall, use of these services declined by 15.6% as measured by mean number of services used, and by 30.2% when considering the number of clients using services. An increase in the mean number of services in psychiatric hospital (5.7%) among fewer clients (34.4%) may indicate that inpatient psychiatric services were being deployed at a slightly higher level of intensity to a smaller, more targeted population of clients most in need of those services. The decreases in number of clients for the remaining 3 service types (EPU, PERT, crisis residential) were all greater than the decreases in mean numbers of those services, indicating that a smaller proportion of clients received higher levels of these emergency services.

USE OF INPATIENT & EMERGENCY SERVICES (PRE/POST)

	12 MONTHS PRIOR TO FSP ENROLLMENT (PRE)		FISCAL YEAR 10-11 (POST)		% CHANGE PRE/POST		MEAN # SERVICES PER CLIENT AMONG USERS		% CLIENTS	
EMERGENCY SERVICE TYPE	# SERVICES	# CLIENTS	# SERVICES	# CLIENTS	MEAN # SERVICES	# CLIENTS	PRE	POST	PRE	POST
EPU	71	49	22	19	-20.1%	-61.2%	1.4	1.2	10.0%	3.9%
PERT	79	56	48	38	-10.5%	-32.1%	1.4	1.3	11.4%	7.8%
Crisis Residential	24	18	21	16	-1.6%	-11.1%	1.3	1.3	3.7%	3.3%
Psychiatric Hospital	111	64	77	42	5.7%	-34.4%	1.7	1.8	13.1%	8.6%
Overall	**285**	**116***	**168**	**81***	**-15.6%**	**-30.2%**	**2.5**	**2.1**	**23.7%**	**16.5%**

Data source: Anasazi 10/2011 and InSyst 10/2008 downloads; California Department of Mental Health Data Collection and Reporting System (DCR) 9/15/2011 download used to identify active clients.

*The overall numbers of clients pre (116) and post (81) indicate unique clients, many of whom used multiple, various services, whereas some clients used no emergency services.

Clients in this analysis (N=490): had an enrollment date <= 7/1/2010 and discontinued date (if inactive) > 7/1/2010.

FSP-Lites strive to help clients work toward recovery while remaining in the community. In FY10-11, there were significant decreases in the number of clients being placed in all restrictive settings: jail, state hospital, and long-term care. Conversely, the number of mean days spent in restrictive settings increased. The data on placement in acute medical settings are considered separately in the table below.

- Only 1 client spent time incarcerated in FY10-11, compared to 8 in the year prior to enrollment. That person had a longer incarceration than clients who were in jail or prison prior to enrollment.
- There were no FSP-Lite clients in FY10-11 with state hospital placement, compared to 5 clients with pre-enrollment placement.
- One client experienced long term care placement in FY10-11 compared to 9 prior to FSP-Lite enrollment. This client's stay was 232 days longer than the average pre-enrollment stay.
- The number of clients spending time in acute medical settings decreased by 30.3%. Those who did require medical care had longer average stays, suggesting that, while fewer clients sought medical care, those who did had access to more intensive medical treatments if needed.

PLACEMENTS IN RESTRICTIVE & ACUTE MEDICAL SETTINGS (PRE/POST)

	12 MONTHS PRIOR TO FSP ENROLLMENT (PRE)		FISCAL YEAR 10-11 (POST)		% CHANGE PRE/POST		MEAN # DAYS PER CLIENT AMONG USERS		% CLIENTS	
TYPE OF SETTING	# DAYS	# CLIENTS	# DAYS	# CLIENTS	MEAN # DAYS	# CLIENTS	PRE	POST	PRE	POST
Jail/Prison	331	8	118	1	185.2%	-87.5%	41.4	118.0	2.1%	0.3%
State Hospital	885	5	0	0	NA	NA	177.0	0.0	1.3%	0.0%
Long-Term Care	1,196	9	365	1	174.7%	-88.9%	132.9	365.0	2.4%	0.3%
Overall	**2,412**	**22***	**483**	**2***	**120.3%**	**-90.9%**	**110.0**	**241.5**	**5.5%**	**0.5%**
Medical Hospital	372	33	543	23	109.4%	-30.3%	11.3	23.6	8.6%	6.0%

Data source: California Department of Mental Health Data Collection and Reporting System (DCR) 9/15/2011 download; 12 month pre-enrollment DCR data rely on client self-report.

Clients in this analysis (N=382): had an Enrollment date <= 7/1/2010 and Discontinued date (if inactive) > 7/1/2011; Clients had to be active throughout the FY to be included.

*The overall numbers of clients pre (21) and post (2) indicate unique clients, many of whom used multiple, various services, whereas some clients used no services.

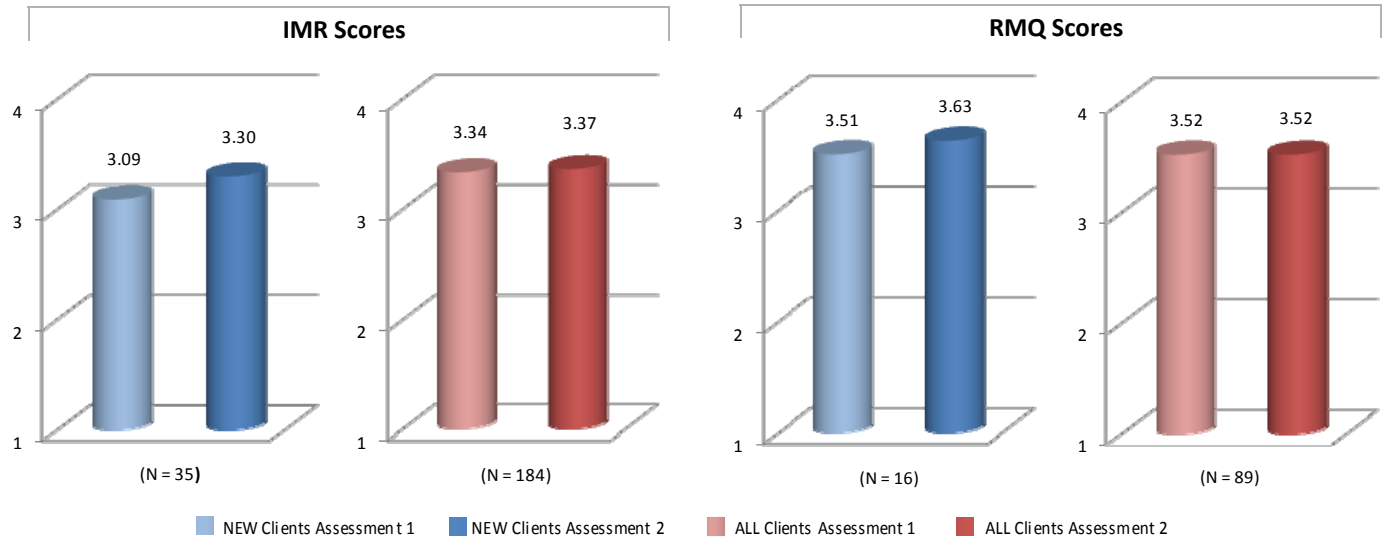
MEASURING PROGRESS TOWARDS RECOVERY

Comparing NEW and ALL FSP-Lite Program Clients

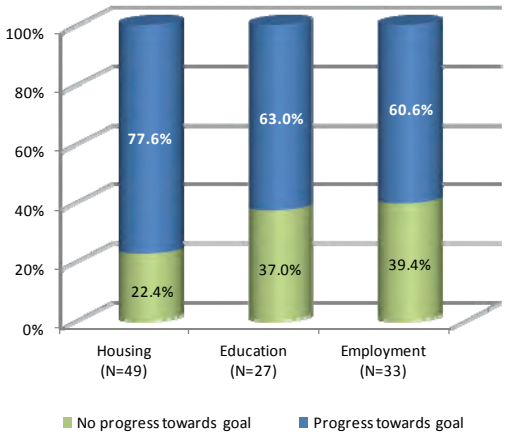
FSP-Lite Clients' progress toward recovery is measured using two different instruments—the Illness Management and Recovery Scale (IMR) and the Recovery Markers Questionnaire (RMQ). Clinicians use the IMR scale to rate their clients' progress towards recovery. The IMR has 15 individually scored items; scores can also be represented using subscales or overall scores. Clients use the 24 item RMQ scale to rate their own progress towards recovery. Higher ratings on both the IMR and the RMQ indicate greater recovery. Scores range from 1-5.

The FSP-Lite client scores displayed in the charts below compare scores of "New Clients" to those of "All Clients." New clients are those who started receiving services in 2010 or later and whose first service date was within 30 days of their first IMR assessment; All Clients includes every client who had both a baseline and follow up IMR assessment, regardless of how long they have received services. Scores for New clients more directly demonstrate the effect of FSP-Lite services on client outcomes because All clients includes those people who may have been receiving services for long periods of time, starting before the implementation of FSP-Lite programming.

IMR Scores increased for both New and All clients. New clients' IMR scores at intake were lower than All clients' scores but New clients achieved greater gains between intake and latest assessment. Both New and All clients' RMQ scores were higher than their IMR scores, indicating that both New and All clients tend to rate their progress higher than do clinicians. RMQ scores for New clients showed progress, whereas RMQ scores for All clients showed no change.



MAKING PROGRESS TOWARDS KEY TREATMENT GOALS



All FSP-Lite Clients Whose Treatment Plan Includes Key Progress Goals — Progress at Latest IMR Assessment

In their IMR assessments, clinicians also note client progress toward goals related to housing, education, and employment. The chart on the left illustrates progress made by those FSP-Lite clients whose treatment plan included one or more of these key goals.

Of those FSP-Lite clients with a housing goal on their treatment plan, 77.6% demonstrated progress toward the goal, while 22.4% did not. Of those with an education goal on their treatment plan, 63% demonstrated progress, while 37% did not demonstrate progress. And of those clients with an employment goal on their treatment plan, 60.6% demonstrated progress toward the goal, while 39.4% did not. Both education and employment were longer-term goals than housing.

Data source for all charts on this page: HOMS FY10-11; Data include all HOMS entries as of 4/5/2012 for clients active in all FSP-Lite Programs during FY10-11 and who had paired IMR/RMQ assessments within 6 months.

Full Service Partnerships
OUTCOMES REPORT

Children's FSP Summary

FY 2010-11

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

What is This?

Full Service Partnership (FSP) programs are comprehensive mental health programs which provide all necessary services and supports, including intensive services, to clients with a high level of need to enable them to live in their community. Services may include in-home and community-based intensive case management to provide support and assistance in obtaining such things such as benefits for low-income families, health insurance, parent education, tutoring, mentoring, youth recreation and leadership development. FSPs may also assist with connections to resources such as physical health services, interpreter services and acquisition of food, clothing, and school supplies.

Why Is This Important?

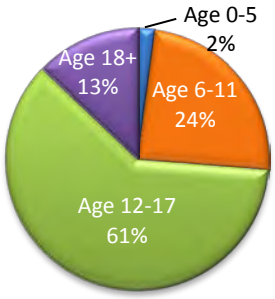
FSP programs support individuals and families, using a "whatever it takes" approach to help stabilize the client. The programs build on client strengths and assist in the development of abilities and skills so clients can become and remain successful. They help clients reach identified goals such as acquiring a primary care physician, increasing school attendance, improving academic performance and reducing involvement with forensic services.

Who Are We Serving?

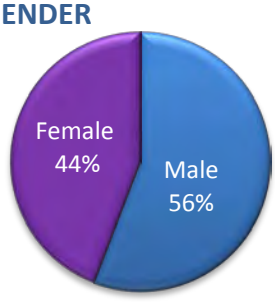
In FY10-11, 529 unduplicated clients received services through the original 3 FSP programs, a 19% increase from the number of FSP clients in FY09-10 (N=446).

FSP Client Demographics & Diagnoses

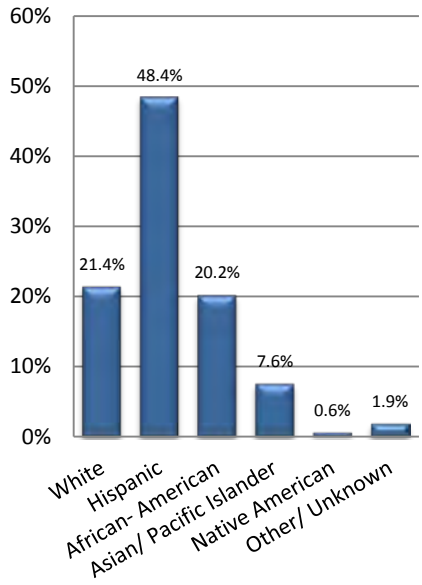
AGE



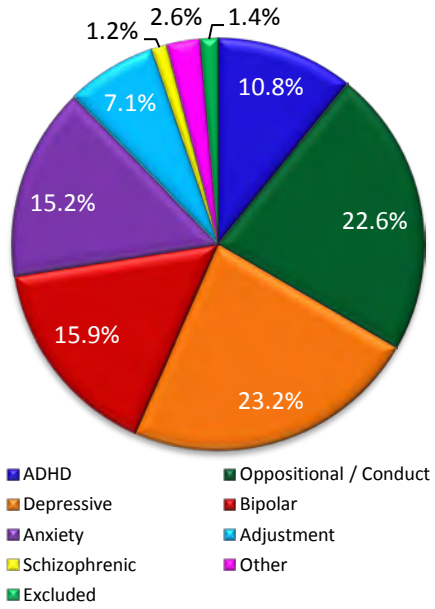
GENDER



RACE/ETHNICITY



PRIMARY DIAGNOSIS

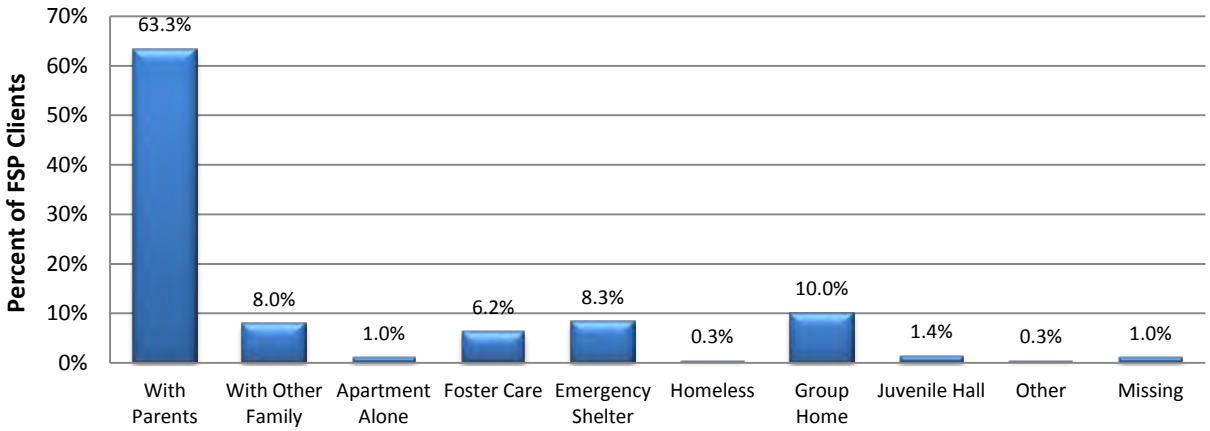


Who Are We Serving?

FSP Providers collected client and outcomes data using the DMH Data Collection & Reporting System (DCR). Residential status and risk factors were entered for new clients to three FSP programs in FY10-11. Referral sources were also entered; FSP referrals in order of frequency were as follows: social service agency (23%), Juvenile Hall (20%), a family member (19%), the school system (16%), a homeless shelter (8%), self-referral (5%), a mental health facility (5%), or a primary care physician (1%).

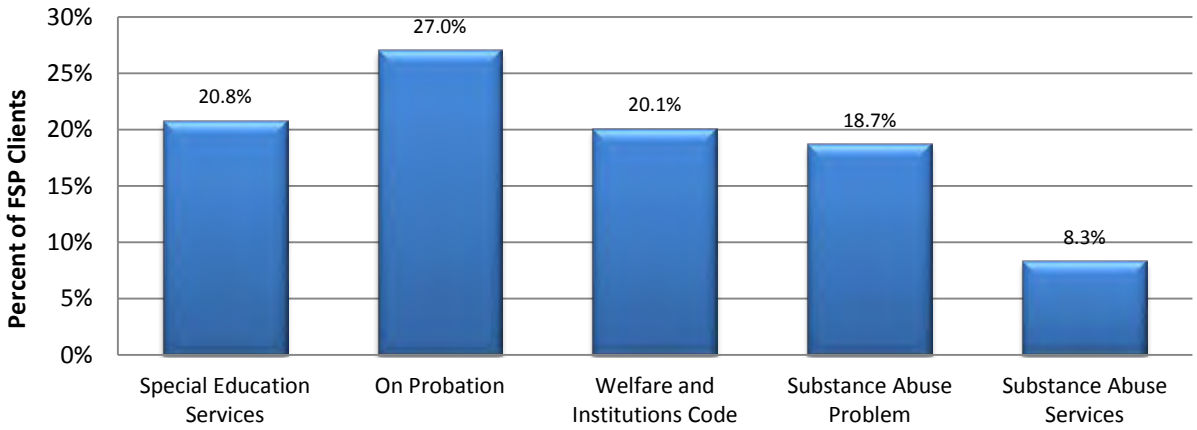
Residential Status at Intake (N=289)

The majority of youth entering FSP programs were living with their parents.



Risk Factors at Intake (N=289)

The most prevalent risk factor among youth entering FSP programs was probationary status. Clients may have had more than one risk factor.

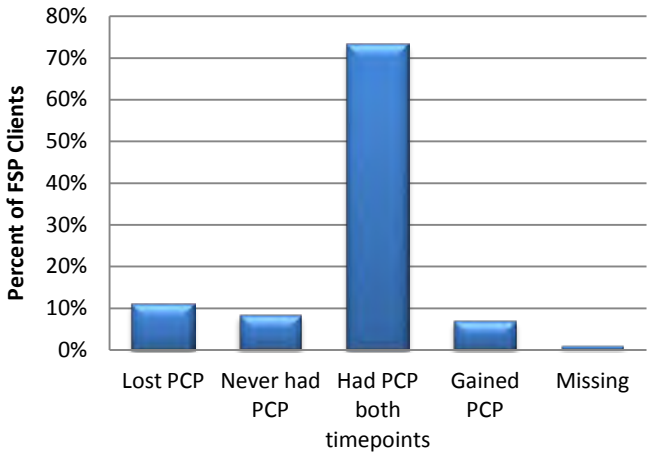


Are Children Getting Better?

FSP Providers also collected client and outcomes data on primary care physician status, school attendance, and academic performance; these were tracked in the DCR for clients with multiple assessments. Analyses of these tracked outcomes were limited to clients with an intake and a 3, 6, 9, or 12 month assessment; the most recent assessment was compared to intake.

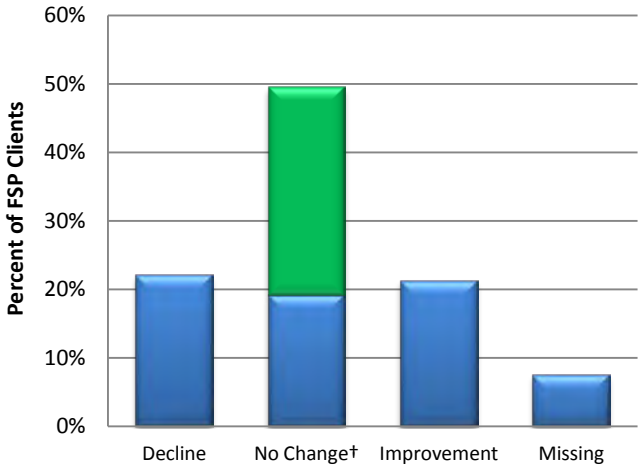
Primary Care Physician (PCP) Status (N=350)

Approximately three-quarters of FSP clients had and maintained a Primary Care Physician.



School Attendance (N=350)

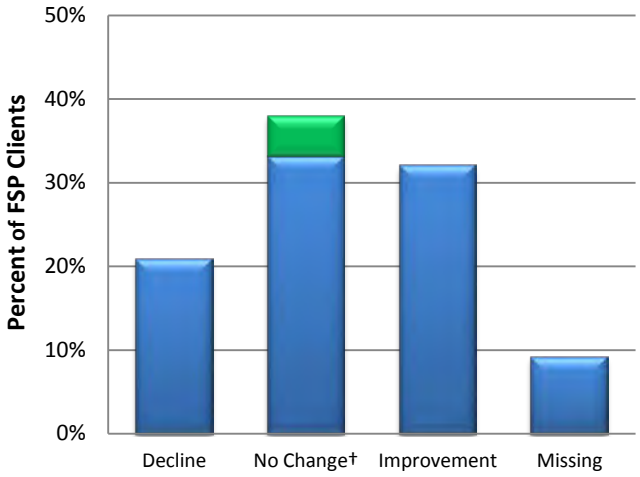
51% of FSP clients either improved or maintained excellent school attendance at follow-up assessment as compared to intake.



†Of the 49% of clients for whom no change was noted, 30% (green portion of bar) had consistently excellent attendance.

Academic Performance (N=350)

37% of FSP clients either improved or maintained excellent grades at follow-up assessment as compared to intake.



†Of the 38% of clients for whom no change was noted, 5% (green portion of bar) had consistently excellent grades.

Forensic Services

In FY10-11, 9 FSP clients had an arrest recorded in the DCR. One FSP client was noted to have been on probation.

Inpatient and Emergency Services

Of the 529 unduplicated clients who received services from an FSP program in FY10-11, 13 (2.5%) had at least one inpatient (IP) episode and 19 (3.6%) had at least one emergency service unit (ESU) visit.

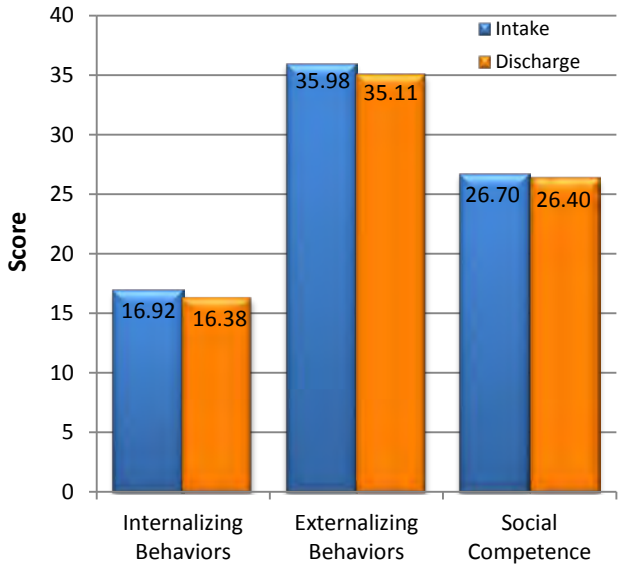
CAMS Scores

The Child and Adolescent Measurement System (CAMS) measures a child's competency, behavior and emotional problems. In FY10-11, the CAMS was administered to all parents/caregivers, and to youth ages 11 and older, at Intake, at UM/UR, and at Discharge. The CAMS was not administered in any inpatient settings.

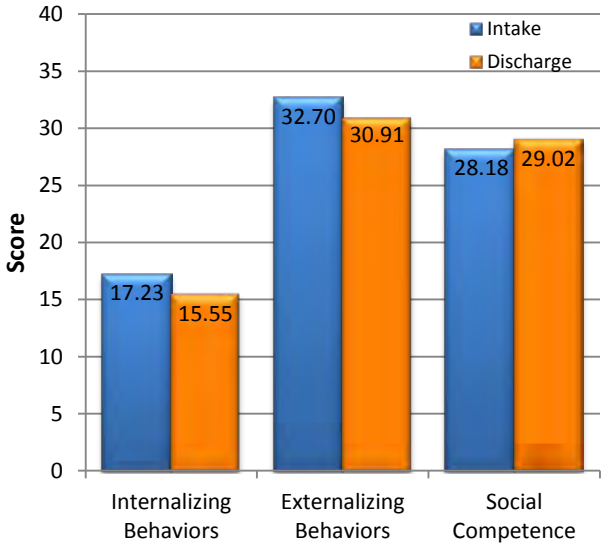
A *decrease* on the Internalizing (e.g., depressive or anxiety disorders) and/or Externalizing (e.g., ADHD or oppositional disorders) CAMS score is considered an improvement. An *increase* in the Social Competence (e.g., personal responsibility and participation in activities) score is considered an improvement.

CAMS scores for youth discharged from FSP services in FY10-11 who had both Intake and Discharge scores for all three scales were analyzed. These CAMS results (N=133 Parent CAMS and N=56 Youth CAMS) **revealed improvement in youth behavior and emotional problems following receipt of FSP services**, with youth reporting greater improvement than caregivers. Parents reported a slight decrease in youth social competency, while youth reported a slight increase.

FSP Caregiver CAMS



FSP Youth CAMS



CASRC is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of the Child & Adolescent Services Research Center (CASRC) is to improve publicly funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

Full Service Partnership Lites OUTCOMES REPORT

Children's FSP Lite Summary

FY 2010-11

What is This?

Full Service Partnership Lite (FSP Lite) mental health programs were established in January 2010 as part of the Community Services and Supports (CSS) component of MHSA. These programs are geared toward clients who have needs greater than can be met by traditional outpatient programs, but who do not need the service intensity of an original FSP program. The broad variety of services provided may include in-home and community-based case management, rehabilitative services and connections to resources such as physical health services.

Why Is This Important?

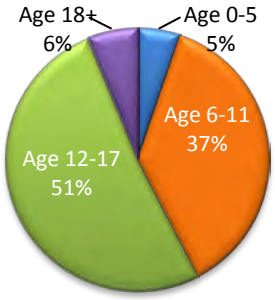
FSP Lite programs wrap around a client, forming a partnership with the family to provide "whatever it takes" to help stabilize the client. The goal of the programs is to build on client strengths and assist in the development of abilities and skills so clients can become and remain successful in the community, while avoiding the need for more intensive mental health services. They assist clients in reaching identified goals such as acquiring a primary care physician, increasing school attendance, and improving academic performance.

Who Are We Serving?

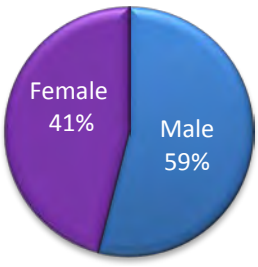
In FY10-11, 1,062 unduplicated clients received services through 10 FSP Lite programs.

FSP Lite Client Demographics & Diagnoses

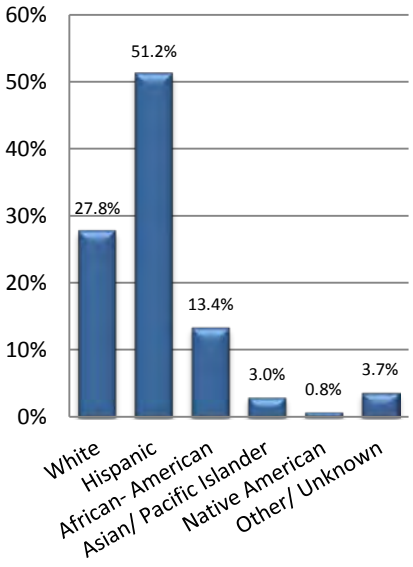
AGE



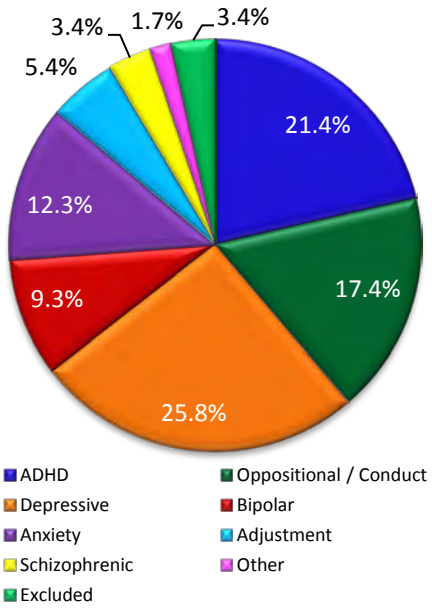
GENDER



RACE/ETHNICITY



PRIMARY DIAGNOSIS

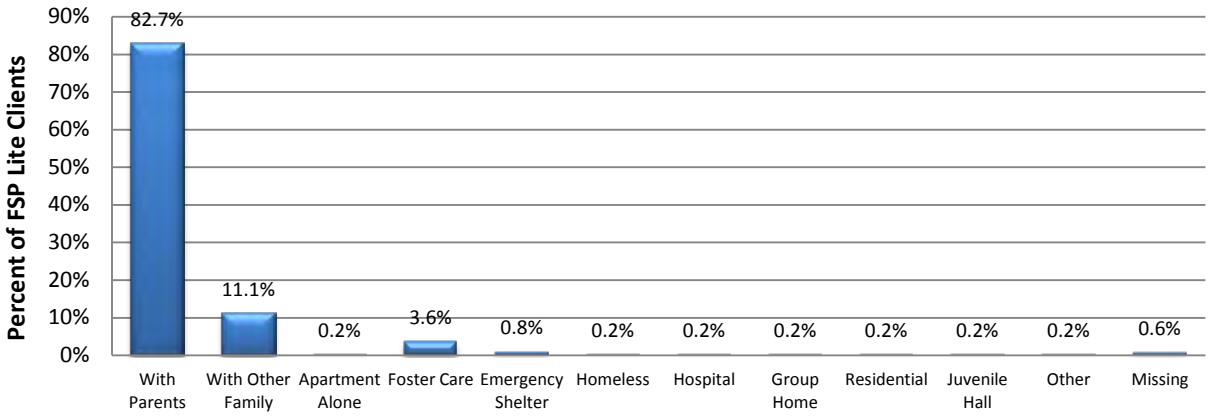


Who Are We Serving?

FSP Lite Providers collected client and outcomes data using the DMH Data Collection & Reporting System (DCR). Residential status and risk factors were entered for new clients to ten FSP Lite programs in FY10-11. Referral sources were also entered; FSP Lite referrals in order of frequency were as follows: school system (33%), a mental health agency (28%), a family member (21%), an acute psychiatric facility (4%), a primary care physician (4%), self-referral (3%), a social service agency (3%), other unspecified (2%), emergency room (1%), other County agency (1%), or a friend (1%).

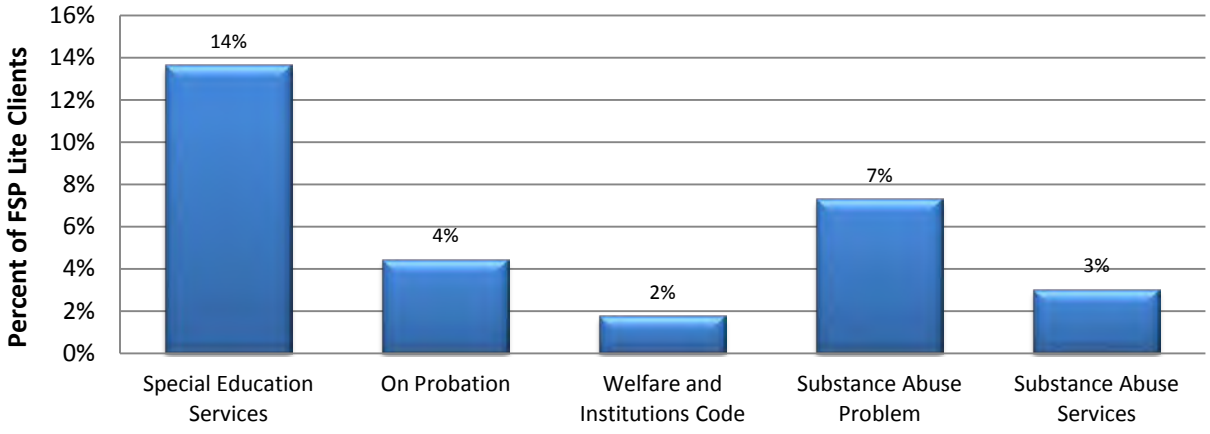
Residential Status at Intake (N=631)

The majority of youth entering FSP Lite programs were living with their parents.



Risk Factors at Intake (N=631)

The most prevalent risk factor among youth entering FSP Lite programs was receipt of Special Education services. Clients may have had more than one risk factor.

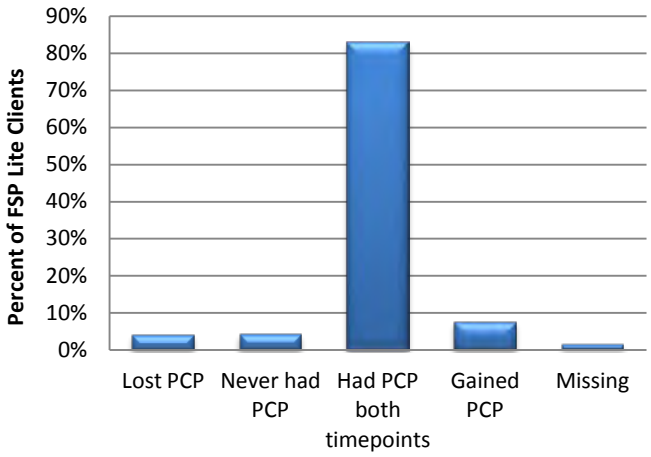


Are Children Getting Better?

FSP Lite Providers also collected client and outcomes data on primary care physician status, school attendance, and academic performance; these were tracked in the DCR for clients with multiple assessments. Analyses of these tracked outcomes were limited to clients with an intake and a 3, 6, 9, or 12 month assessment; the most recent assessment was compared to intake.

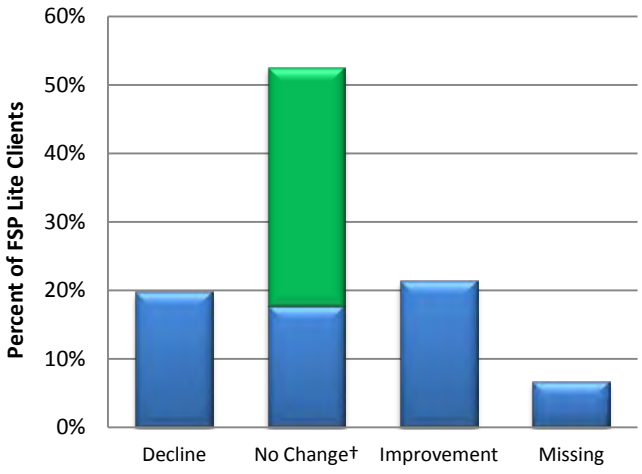
Primary Care Physician (PCP) Status (N=696)

More than 80% of FSP Lite clients had and maintained a Primary Care Physician.



School Attendance (N=696)

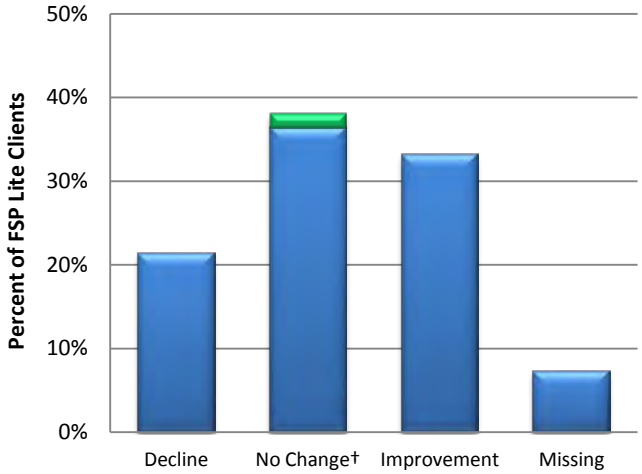
56% of FSP Lite clients either improved or maintained excellent school attendance at follow-up assessment as compared to intake.



†Of the 53% of clients for whom no change was noted, 35% (green portion of bar) had consistently excellent attendance.

Academic Performance (N=696)

35% of FSP Lite clients either improved or maintained excellent grades at follow-up assessment as compared to intake.



†Of the 38% of clients for whom no change was noted, 2% (green portion of bar) had consistently excellent grades.

Forensic Services

In FY10-11, 8 FSP Lite clients had an arrest recorded in the DMH Data Collection & Reporting System (DCR). No FSP Lite clients were noted to have been on probation.

Inpatient and Emergency Services

Of the 1,062 unduplicated clients who received services from an FSP Lite program in FY10-11, 41 (3.9%) had at least one inpatient (IP) episode and 35 (3.3%) had at least one emergency service unit (ESU) visit.

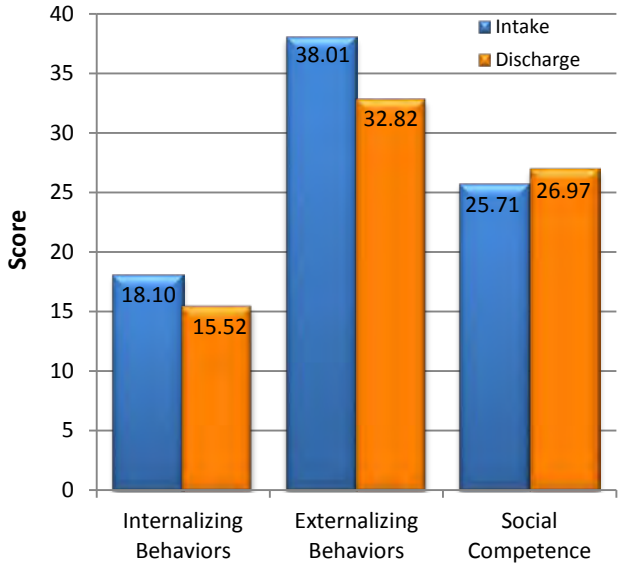
CAMS Scores

The Child and Adolescent Measurement System (CAMS) measures a child's competency, behavior and emotional problems. In FY10-11, the CAMS was administered to all parents/caregivers, and to youth ages 11 and older, at Intake, at UM/UR, and at Discharge. The CAMS was not administered in any inpatient settings.

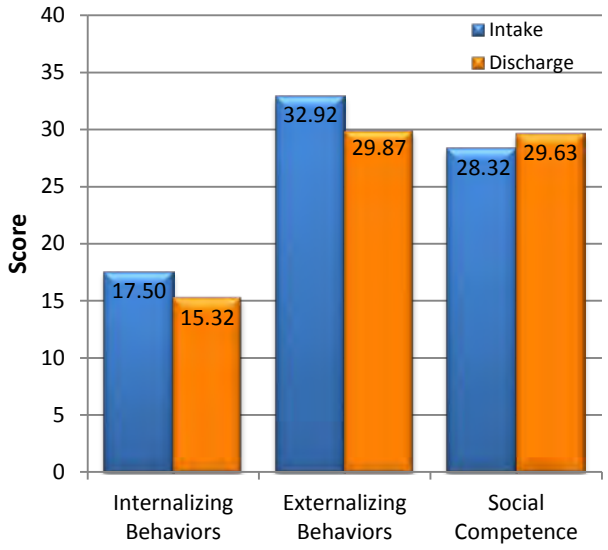
A *decrease* on the Internalizing (e.g., depressive or anxiety disorders) and/or Externalizing (e.g., ADHD or oppositional disorders) CAMS score is considered an improvement. An *increase* in the Social Competence (e.g., personal responsibility and participation in activities) score is considered an improvement.

CAMS scores for youth discharged from FSP Lite programs in FY10-11 who had both Intake and Discharge scores for all three scales were analyzed. These CAMS results (N=79 Parent CAMS and N=60 Youth CAMS) **revealed improvement in youth behavior and emotional problems following receipt of FSP Lite services**, as reported by both youth and caregivers.

FSP Lite Caregiver CAMS



FSP Lite Youth CAMS



CASRC is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of the Child & Adolescent Services Research Center (CASRC) is to improve publicly funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

Peer Support Specialists Adult/ Older Adult Outcomes Report

May, 2011

HealthServices Research Center
University of California, San Diego

County of San Diego HHSA
Health and Human Services Agency

PEER SUPPORT SPECIALISTS: TANGIBLY MAKING A DIFFERENCE

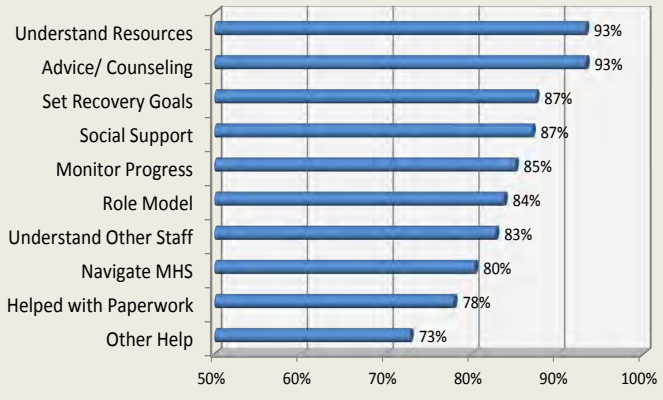
PEER SUPPORT SPECIALIST:

Someone who has progressed in their own recovery from mental illness and can now offer professional services to mental health consumers. Because of their life experience they provide expertise that professional training cannot replace.*

Clinics in the San Diego Mental Health Services System often have former or current clients performing the role of Peer Support Specialist (PSS). PSSs help bridge the gap between clients' needs and the SDCMHS's ability to meet those needs. A PSS offers support to clients from the unique perspective of "someone who's been there." They provide a resource to programs and clinics that can potentially expand the services and insights available to mental health consumers. Given their widespread presence in the mental health system in San Diego and many other counties throughout the U.S.A., it is important to assess the presence, function, and effectiveness of these specialists.

During the Spring of 2010, as part of the bi-annual Consumer Satisfaction Survey, SDCMHS clients were asked about their experience(s) with PSSs. The survey included 19 items assessing the potential functions often performed by PSS's, questions about the effectiveness of any services provided, and an area to write additional comments about Peer Support Specialists.

What types of help did the Peer Support Specialist/Counselor provide?



Results: Among the 1342 clients who responded to the Spring 2010 Consumer Satisfaction Survey, 570 clients (47%) reported having interacted with a Peer Support Specialist during the course of their care with SDCMHS. PSS users were 51% males and 49% females and 71% were adults between the ages of 25 and 59. Fifty-two percent of PSS users were from outpatient programs (OP), 41% were from full service partnerships (FSP), and 7% were from case management programs (CM).

The Peer Support Specialist/Counselor...

Types of Help Received: Clients received the most help from PSS's in the areas of Understanding Resources and Advice/Counseling (93% and 93%, respectively); this was true across all diagnostic categories as well as across program types.

Perceptions of PSS Services: Clients were asked to rate whether they strongly agree, agree, disagree, strongly disagree, or were neutral about specific statements pertaining to their experiences with their PSS. Eighty-five percent of clients agreed or strongly agreed that PSSs helped them believe that they could recover. Eighty-five percent of clients also reported that their PSS provided helpful thoughts and insights. Eighty-three percent of clients agreed or strongly agreed that their PSS understood what they were going through and 78% reported that their experience with a PSS made a difference in their recovery.

*Michigan Department of Community Health, Bulletin MSA 07-52: Revisions to Mental Health and Substance Abuse Chapter, September 1, 2007.

PEER SUPPORT SPECIALISTS: CLIENT COMMENTS...

"Encouraged my progress, advised me on success!"

Additional space on the survey form was provided for clients to write comments about PSSs. Relevant comments were coded into the general categories "positive," "negative," and "neutral." A comment was coded as positive or negative when it indicated a positive or negative attitude or contained language regarding individual staff, roles, program-run groups and/or facilities.

"The PSSs here rock!"

" I think that it is wonderful to have peer support because peers under-stand exactly where we're coming from."

"They treat me like I am somebody."

"Give them a raise!"

All Client Comments	N	%
Positive	171	68%
Negative	7	3%
Unclear/Off-topic	72	29%
Neutral/ No Opinion	1	0%
Total	**251**	**100%**

Positive Comments: Sixty-eight percent of the 251 comments were of a "positive" nature. Most of these comments included general praise about Peer Support Specialists.

Further evaluation of the "positive" category found that most responses contained multiple statements and themes that could be further classified into 6 themed subcategories: Praise/ Gratitude; Social/ Emotional Support; Recovery Support; Practical/ Logistical Support; Wants More; and Needs Information (see table below).

Positive Themes	N	%
Social/Emotional Support	86	44%
High Praise/ Gratitude	55	28%
Recovery Support	26	13%
Practical/Logistical Support	15	8%
Wants More	13	7%
Needs Information	28	14%
Total	**195**	**100%**

Most clients considered their experience with a PSS beneficial in some way, with 44% of comments about how their PSS provided social/ emotional support, recovery support (13%), and/or practical/logistical support (8%). Twenty-eight percent contained high praise & gratitude.

"They have high values and helped me to see that I really matter…"

Clients with comments in the "Wants More" category (7%) either stated they wanted more peer support contact or would like to become a PSS. The comments categorized as "Needs Information" (14%) had either never seen a PSS (and were interested) or were unaware of PSS services as a resource for their recovery and wanted to know more.

Negative Comments: Three percent of all the comments received (7 out of 251 comments) were negative. Among the persons that did not find the PSS to be helpful, two felt that they were doing fine on their own and three stated that the PSS was "not good."

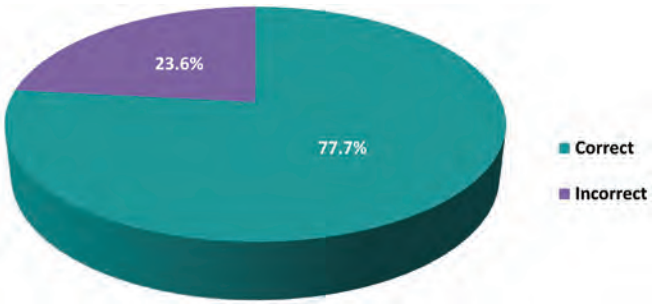
"Have yet to find one suitable to be someone who can help me truly."

Unclear/ Off-topic Comments: Twenty-nine percent of the comments were coded Unclear/ Off-topic. When looking more closely at these comments, we find that many people had something to communicate and even though it was unrelated, they chose to voice it here. Examples of these comments include complaints about the length of the survey, the facility or (non-PSS) staff.

Neutral/ No Opinion: This category consisted of one comment that stated, "Neutral. That's all."

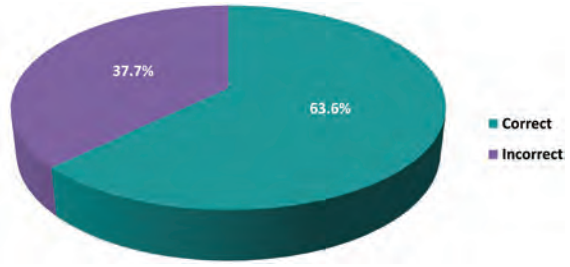
PROGRAM SPECIFIC OUTCOMES

PERCENT OF STUDENTS WHO CORRECTLY IDENTIFIED WARNING SIGNS OF SUICIDE.



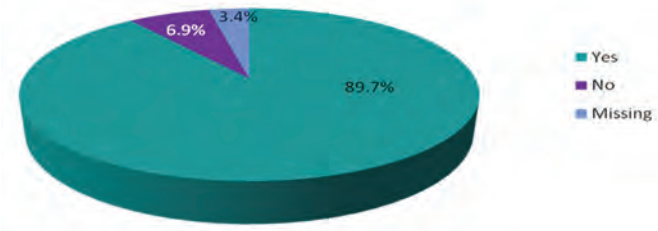
Following the presentation, approximately 78% of students in the sample correctly identified the warning signs of suicidal ideation/ behavior.

PERCENT OF STUDENTS WHO CORRECTLY IDENTIFIED THE STEPS TO TAKE IF A FRIEND SAYS HE/SHE IS CONSIDERING SUICIDE.



Following the presentation, approximately 64% of students in the sample correctly identified the steps to take if a friend is considering suicide.

IF I FELT DEPRESSED OR WAS HAVING SUICIDAL THOUGHTS, I KNOW WHO TO GO TO FOR HELP:



Following the presentation, roughly 88% of students in the sample reported that if they were depressed or were having suicidal thoughts, they would know who to go to for help.

SUICIDE RISK REFERRALS	N
Referrals from FY2009-2010	130
Referrals from FY2010-2011	264
Referrals from schools that received presentations FY2010-2011	169 (64%)
Referrals that were made before the presentations	*103 out of 169*
Referrals that were made after the presentations	*66 out of 169*
Referrals from schools that did not receive presentations FY2010-2011	95 (36%)

One of the goals of this PEI program is to increase the identification of students who are at risk for suicidal ideation and behavior. A greater number of students were identified in 2010-2011 (the year the PEI program began) than in 2009-2010.

The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

APPENDIX B – PREVENTION AND EARLY INTERVENTION OUTCOMES REPORTS

DRAFT

SAN DIEGO PEI PROGRAMS

SYSTEMWIDE REPORT

SAN DIEGO COUNTY CHILD & ADULT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

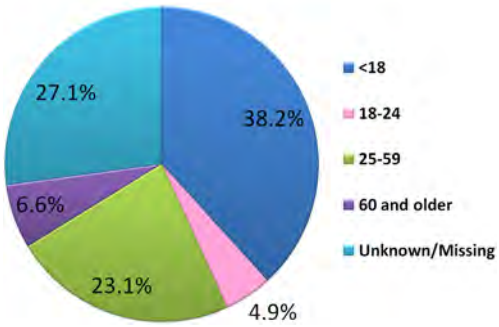
Report completed by the Health Services Research Center (HSRC) and the Child and Adolescent Services Research Center (CASRC)

The Mental Health Services Act Prevention and Early Intervention funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. San Diego County has funded 25 contractors to provide prevention and early intervention (PEI) programs for adults and 10 contractors to provide PEI programs for youth and their families. The focus of these programs vary widely, from reducing the stigma associated with mental illness to preventing youth suicide. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided. This information is summarized in the following report.

DATA:	Child and Adult PEI Programs
REPORT PERIOD:	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	31,728 unduplicated [1,2]
1. Data not available for some participants in the ACE, KickStart, and School-Based East County programs.	
2. Data for all students participating in the Yellow Ribbon Suicide Prevention program were calculated from a representative sample of students who provided demographic and satisfaction information.	

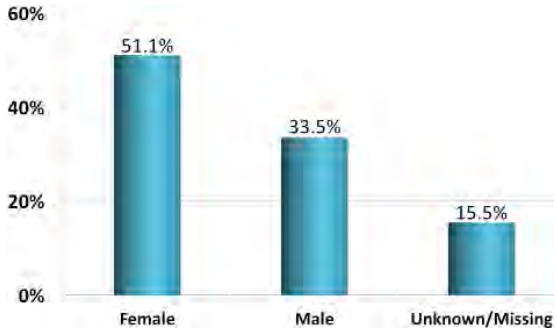
SYSTEMWIDE PARTICIPANT DEMOGRAPHICS*

AGE



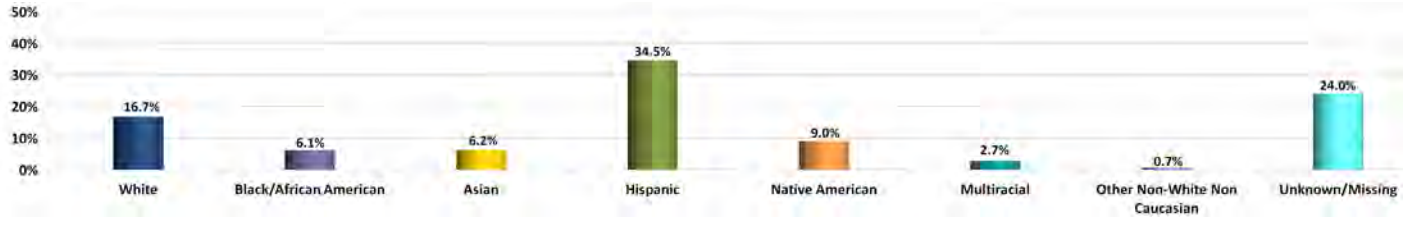
Of the participants who reported their age, the majority were either under 18 or between the ages of 25-59.

GENDER



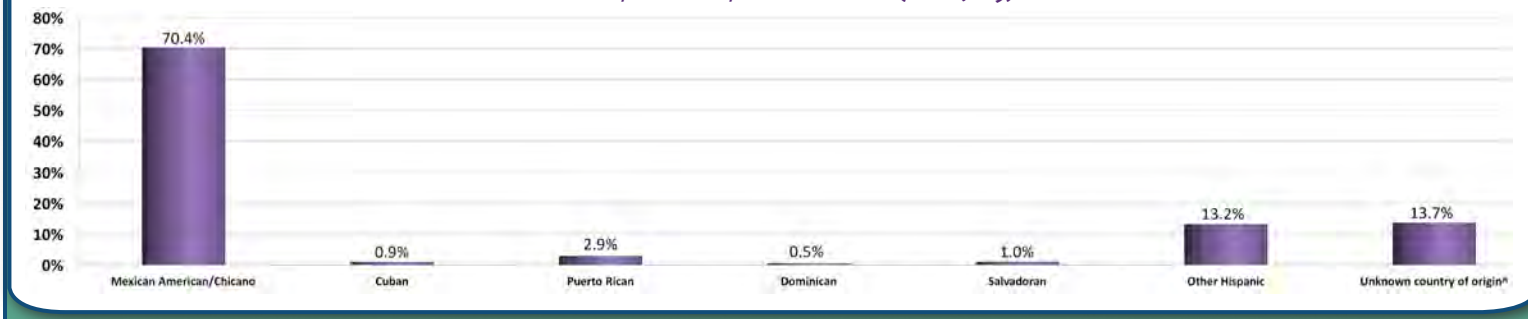
More than half of the participants who received services were female.

RACE/ETHNICITY



Slightly more than one-third of participants who received services identified their ethnic background as Hispanic.

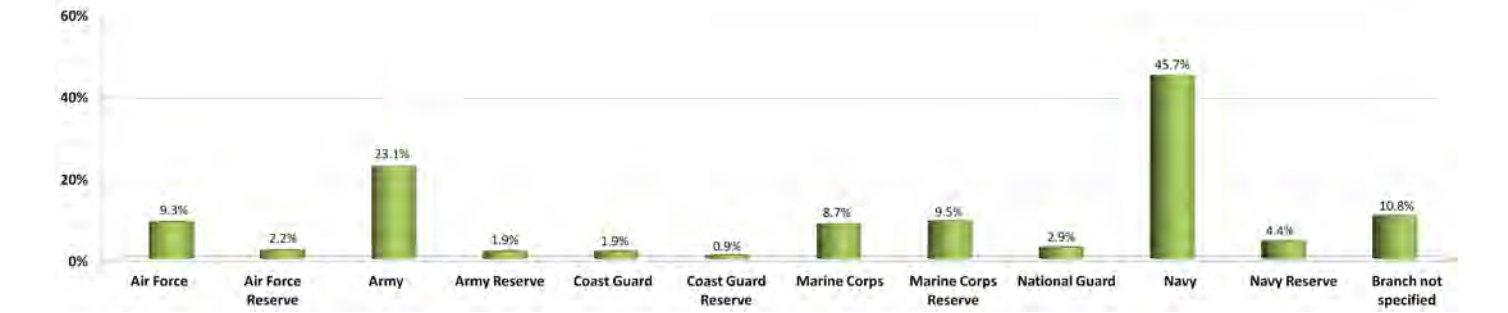
** The percentage of participants with unknown or missing information is high because individuals who called the Adult/Family Peer Support Line, one of the largest PEI programs, often did not report their demographics.*



Of the Hispanic population served, 72% identified their ethnic background as Mexican American/Chicano.

Participants can self-identify as more than one race so percentages may add up to more than 100%.
^Some PEI programs did not ask Hispanic participants to list their country of origin. Participants from these programs are included in the unknown category.

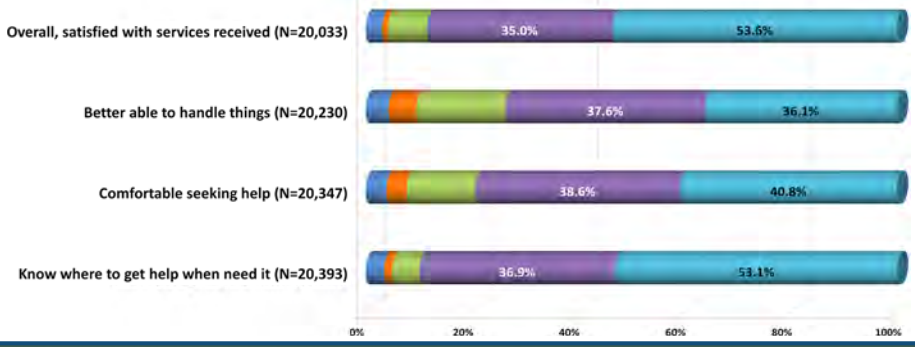
MILITARY SERVICE



In the adult PEI programs, participants were asked about their own military involvement. The children's PEI programs reported whether the children's caregivers had served in the military. Of the 26,418 participants in both systems who reported on military involvement, only 2,551 (10%) stated that either they or their child's caregiver had served in the military. The majority of these individuals served in the Navy (46%) or the Army (23%). The remaining military branches were not highly respresented.

** Participants could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



Information on satisfaction with the PEI programs was available for approximately 63% of the participants. Of these participants, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 89% of the participants who responded were satisfied with the services they received.

**Satisfaction data not available for all participants.*

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ADULT PEI PROGRAMS

SYSTEMWIDE REPORT

SAN DIEGO COUNTY ADULT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Report completed by the Health Services Research Center (HSRC)

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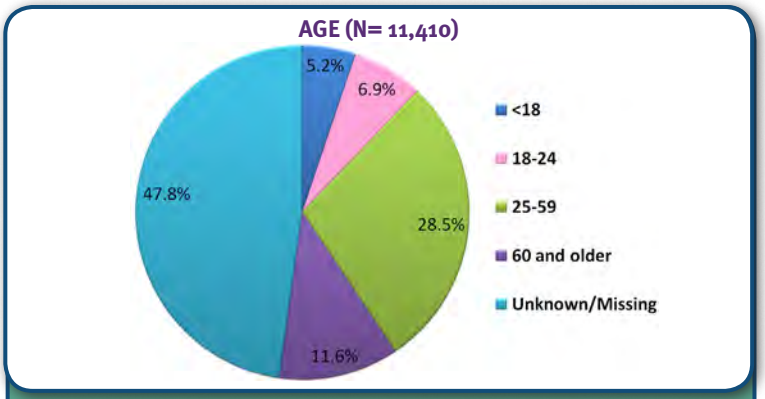
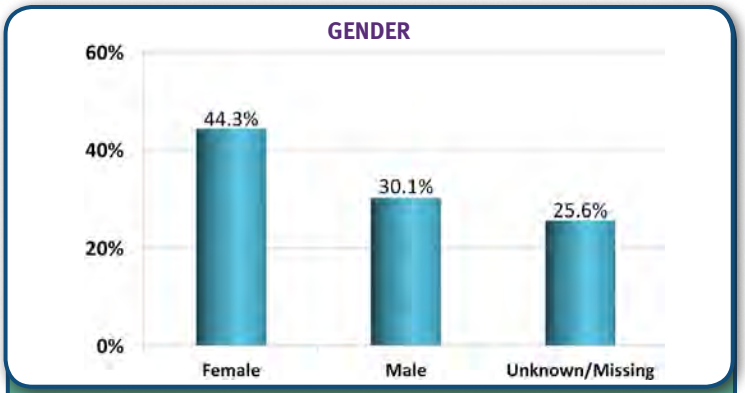
DATA:	Adult PEI Programs
REPORT PERIOD:	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	11,800 unduplicated

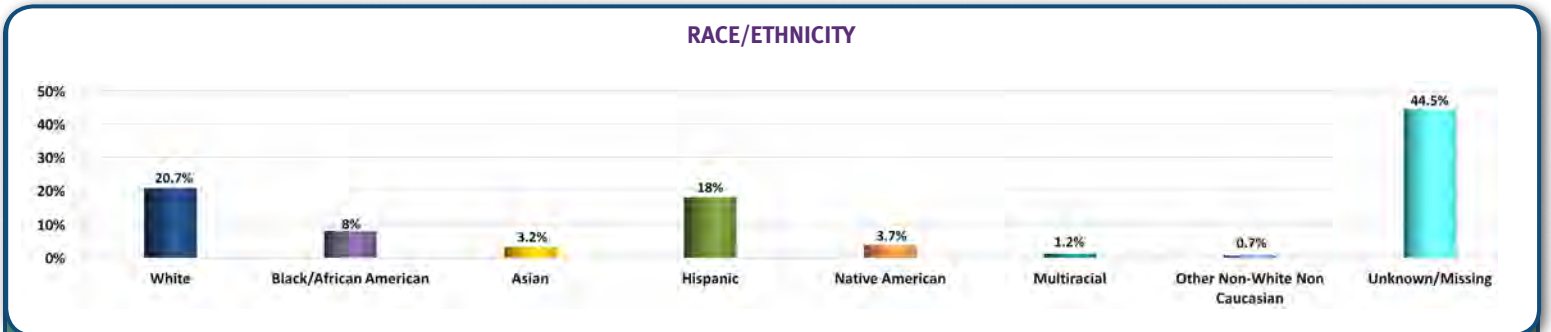
SYSTEMWIDE PARTICIPANT DEMOGRAPHICS*



Of the participants who reported their age, the majority were ages 25-59.

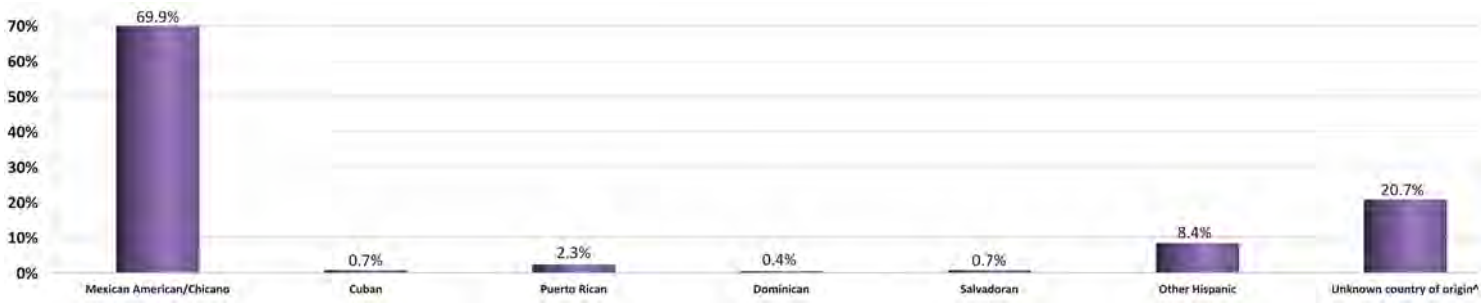


Most of the participants who reported their gender were female.



Most of the participants who reported their racial/ethnic background identified as White or Hispanic.

** The percentage of participants with unknown or missing information is high because individuals who called the Adult/Family Peer Support Line, one of the largest PEI programs, often did not report their demographics.*

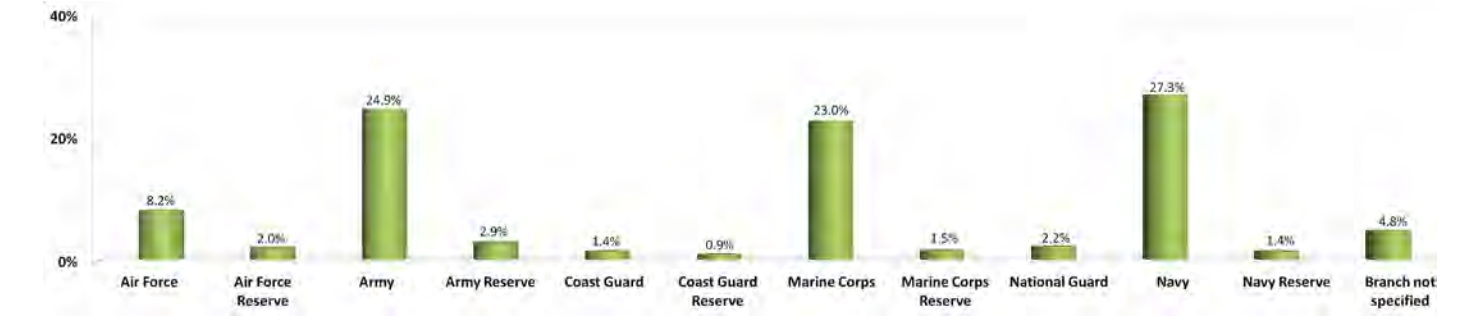


Of the Hispanic population served, 70% identified their ethnic background as Mexican American/Chicano.

Participants can self-identify as more than one race so percentages may add up to more than 100%.

^Some PEI programs did not ask Hispanic participants to list their country of origin. Participants from these programs are included in the unknown category.

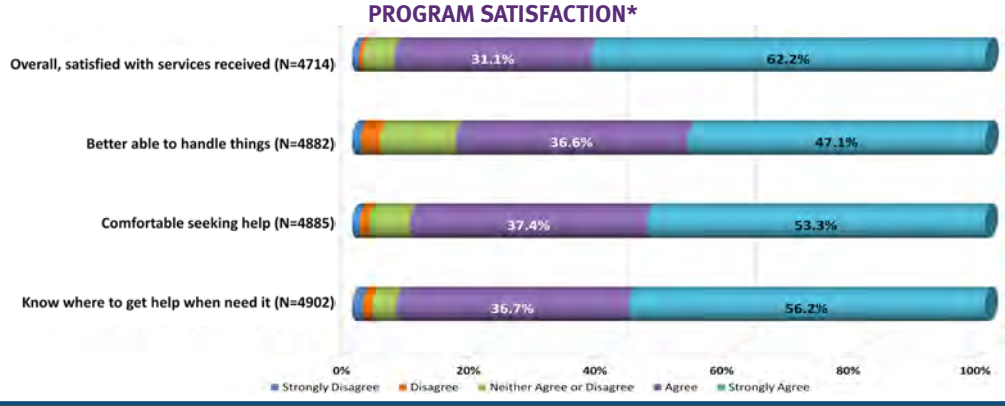
MILITARY SERVICE



Of the 8,727 participants who reported on military involvement, 584 (8%) had served in the military. Of those participants, 27% served in the Navy, 25% served in the Army and 23% served in the Marine Corps. The remaining military branchs were not as highly represented.

** Participants could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



Information on satisfaction with the PEI programs was available for approximately 40% of the participants. Of these participants, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 93% of the participants who responded were satisfied with the services they received.

**Satisfaction data not available for all participants.*

The Health Services Research Center (HSRC) at University of California, San Diego is a non-profit research organization within the Department of Family and Preventive Medicine. HSRC works in collaboration with the Performance Outcomes and Quality Improvement Unit of San Diego County Mental Health Services to evaluate and improve mental health outcomes for County residents. Our research team specializes in the measurement, collection and analysis of health outcomes data to help improve health care delivery systems and, ultimately, to improve client quality of life. For more information please contact Andrew Sarkin, PhD at 858-622-1771.

CHILDREN'S PEI PROGRAMS

SYSTEMWIDE REPORT

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Report completed by the Child and Adolescent Services Research Center (CASRC)

The Mental Health Services Act Prevention and Early Intervention funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. San Diego County has funded 10 contractors to provide prevention and early intervention (PEI) programs for youth and their families. The focus of these programs vary widely, from teaching caregivers how to cope with behavior problems in young children to preventing youth suicide. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided. This information is summarized in the following report.

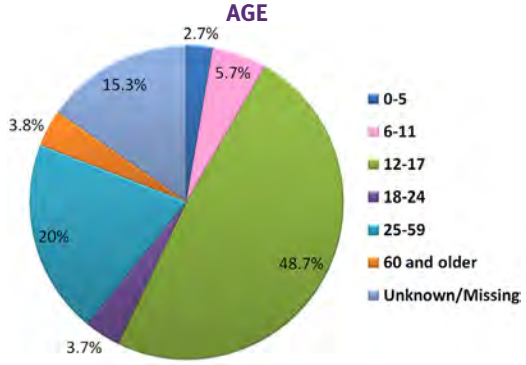
DATA:	Child and Adolescent PEI Programs
REPORT PERIOD:	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	19,928 unduplicated [1,2]

1. Data not available for some participants in the ACE, KickStart and School-Based East County Programs.

2. Data for all students participating in the Yellow Ribbon Suicide Prevention program were calculated from a representative sample of students who provided demographic and satisfaction information.

SYSTEMWIDE PARTICIPANT DEMOGRAPHICS

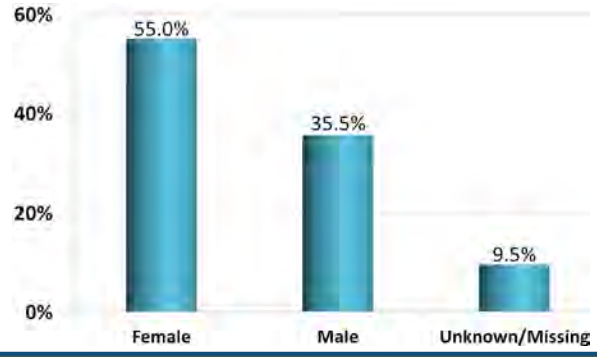
AGE



Of the participants who reported their age, the majority were ages 12-17. Some participants were older than 18 because serveral children's PEI programs include caregivers and community members.

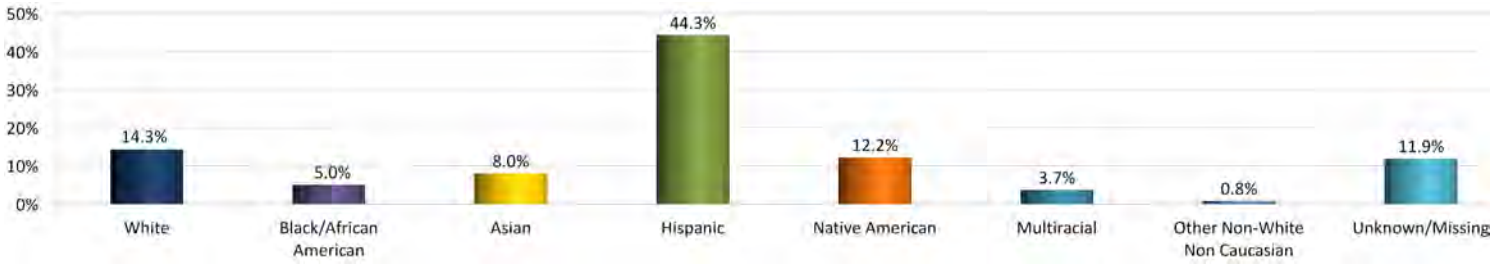
**Many of the individuals who called the Family Support Line, and all of the staff who participated in the Yellow Ribbon Suicide Prevention program, did not report their age.*

GENDER



The majority of the participants who received services were female.

RACE/ETHNICITY

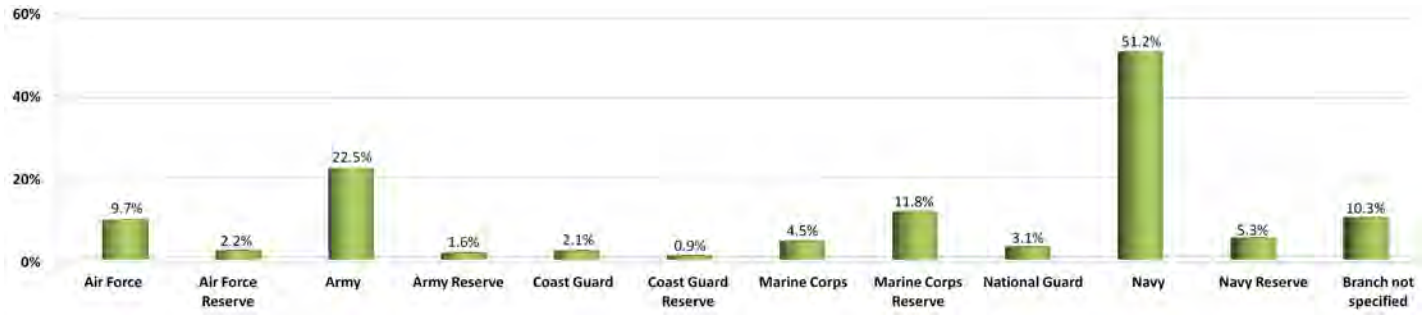


Approximately 44% of participants who received services identified their ethnic background as Hispanic.

Of the Hispanic population served, 71% identified their ethnic background as Mexican American/Chicano.

Participants can self-identify as more than one race so percentages may add up to more than 100%.
^Some PEI programs did not ask Hispanic participants to list their country of origin. Participants from these programs are included in the unknown category.

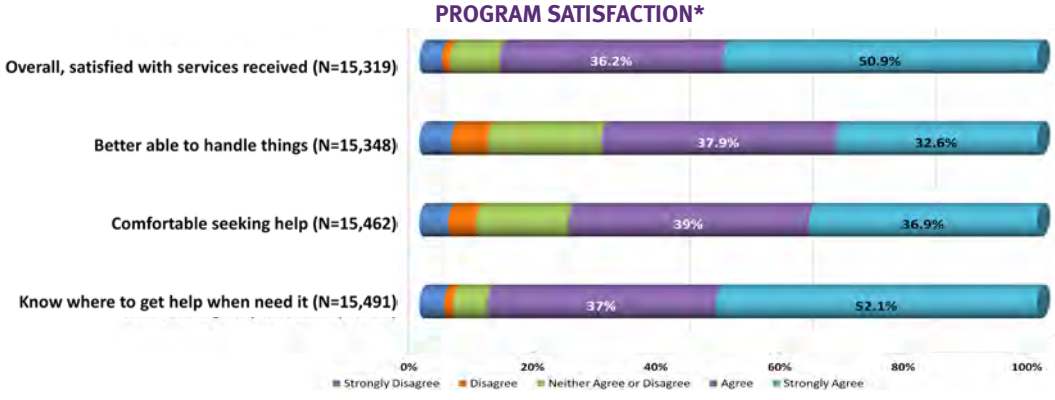
CAREGIVER INVOLVEMENT IN MILITARY SERVICE



Of the 17,691 participants who reported on caregiver involvement in the military,1964 (11%) reported that the youth's caregiver had served in the military. Of these caregivers, 51% served in the Navy and 23% served in the Army. The remaining branches were not as highly respresented.

** Participants could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



Information on satisfaction with the PEI programs was available for approximately 77% of the participants.
Of these participants, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 87% of the participants who responded were satisfied with the services they received.

**Satisfaction data not available for all participants.*

The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

It's Up to Us

PS01 — All Regions and Districts of San Diego

4/3/12

Public Awareness and Stigma Reduction Campaign

As of spring 2011, the It's Up to Us campaign included six 30-second television and radio commercials, two of each in Spanish and four in English, along with English and Spanish posters and billboards, bus billboards, and bus shelters. These spots encouraged San Diegans to "speak up" and get help, or "listen up" and offer support. Viewers were directed to visit Up2SD.org, or to call an access and crisis line for information about mental illness and treatment resources.

AdEase, a San Diego based advertising, marketing and public relations firm, was contracted to develop the It's Up to Us campaign materials. The first series of materials addressed general mental health stigma and subsequent materials will address additional topics such as suicide and mental health resources. Materials will also be targeted towards specific high-risk populations.

In collaboration with AdEase, Strata Research Inc. (Strata) conducted random digit dialed phone surveys to assess campaign impact. Data to date includes Wave I (a baseline study completed six months prior to campaign launch), and Wave II (a follow-up study completed six months after the campaign launch). Additional Waves of the study will completed annually.

Finally, UCSD's Health Services Research Center (HSRC) was contracted to complete independent direct exposure surveys to determine the specific effects of each component of the campaign. Data will be used to help develop and target specific messages.

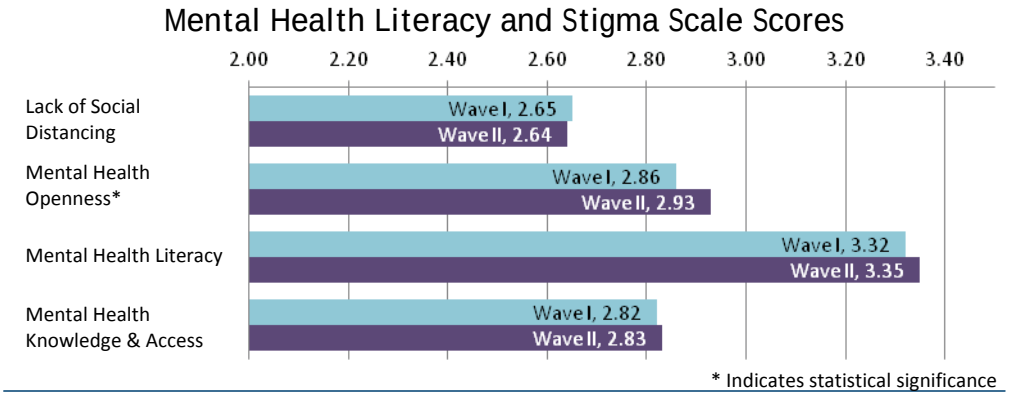
The HHSA implemented this campaign through funding from the Mental Health Services Act (MHSA). Originally passed by voters as proposition 63, the MHSA became state law effective January 1, 2005. The MHSA provides state funding to counties for expanded and innovative mental health programs.

Methods

Wave I of the study, conducted by Strata in April 2010, had 602 respondents and Wave II, conducted in March 2011, had 601 respondents. Each Wave assessed current knowledge of and attitudes towards mental illness.

The HSRC direct exposure study was conducted in March 2011, and had 120 respondents. In this study, participants listened to the audio from each of the It's Up to Us television commercials, and were asked for their reactions to specific components of each.

Data will help attribute specific improvements to the media campaign, as many outside factors can influence responses.



Respondents in Wave I and Wave II listened to a scenario about a character with either depression or schizophrenia, and were then asked questions to determine their knowledge of the character's condition, and their feelings towards the character.

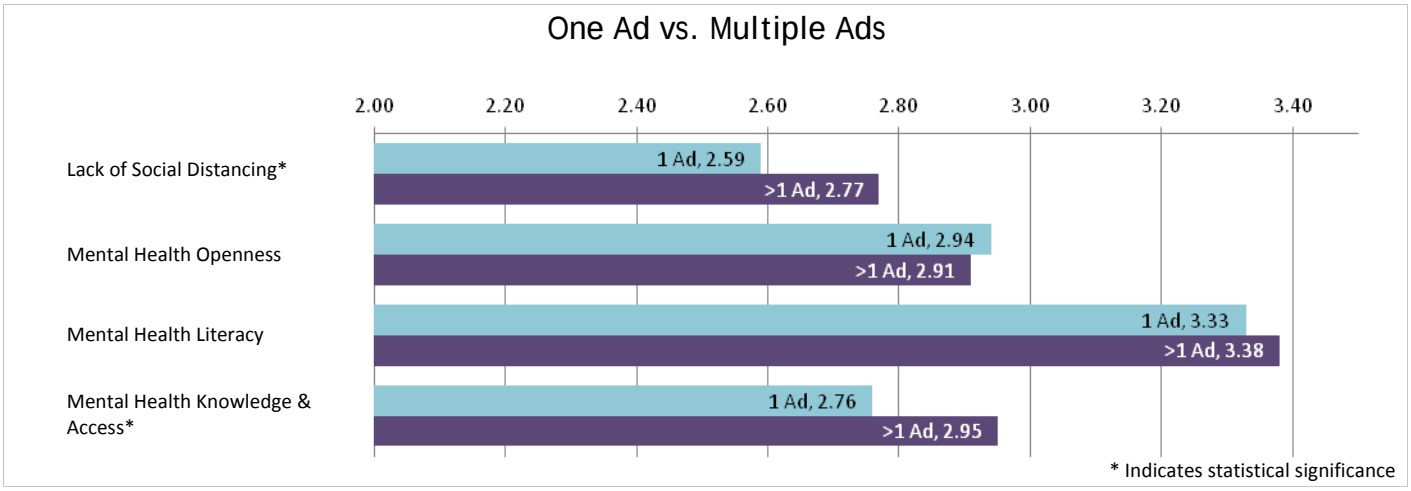
These questions made up the Lack of Social Distancing, Mental Health Openness, Mental Health Literacy, and Mental Health Knowledge & Access scales, which address different aspects of mental health stigma and literacy as well as treatment and recovery. For each of the scales, a higher score represents a more positive result.

From Wave I to Wave II, there was a significant increase in the Mental Health Openness scale for the overall population. This indicates that respondents associated less stigma with discussing mental health problems, and would feel more open to speaking about their personal mental health problems than they did at Wave I.

Literacy and Stigma Scales

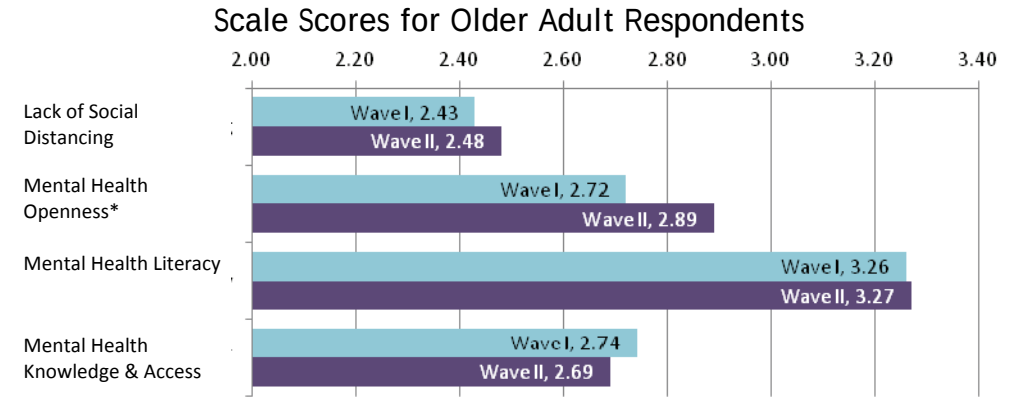
To gauge the effect of viewing multiple It's Up to Us spots, scale scores were compared for respondents with different levels of campaign exposure in Wave II of the study.

- Respondents who saw more than one spot scored significantly higher than those who only saw one spot on the Lack of Social Distancing scale and the Mental Health Knowledge & Access scale.
- Respondents who saw all four spots scored significantly higher than those who saw fewer ads on the Mental Health Openness scale.



Effects on Select Target Populations

Specific components of the It's Up to Us campaign were targeted at different populations within San Diego County, including transition aged youth (TAY), older adults (ages 65+), and Hispanic adults.

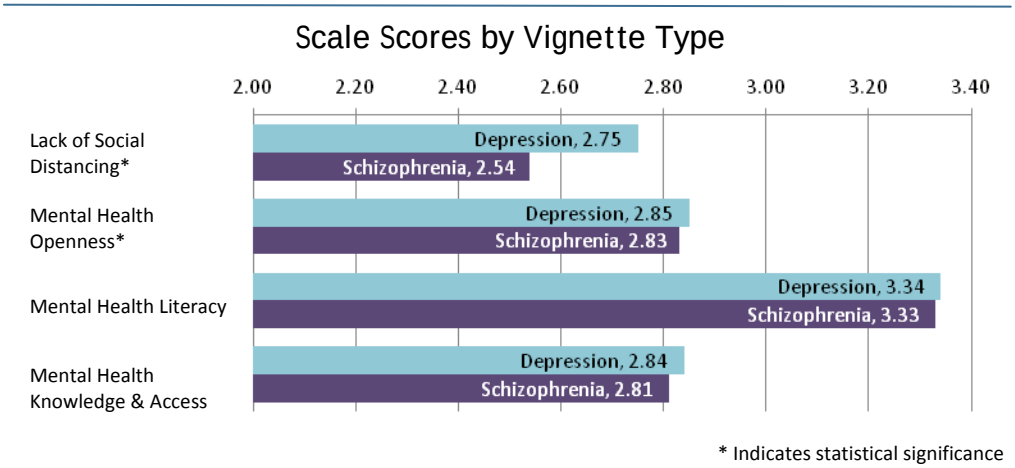


At Wave II, older adults had significantly higher scores on the Mental Health Openness scale than at Wave I. This shows reduced stigma and indicates that they might be more likely to seek help if they are concerned about their mental health. At Wave II, older adults were also more likely to report that they were currently receiving treatment, or had received treatment in the past year than at Wave I.

There were no significant differences in scale scores for Hispanic or TAY respondents.

Vignette Type

Scale scores were also compared for respondents based on which vignette they heard. Overall, respondents' scores on the two stigma scales were significantly higher if they heard the depression vignette than if they heard the schizophrenia vignette. This indicates that there is currently more stigma towards people with schizophrenia than people with depression.



Effects of Viewing Specific Media Spots

Scale scores differences were examined for respondents who had previously viewed each of the spots. Respondents who had seen "Bill & Doug" scored significantly higher on the Lack of Social Distancing, Mental Health Literacy, and Mental Health Knowledge & Access scales. Respondents who had seen "Tyler" or "Older Adults" scored significantly higher on the Lack of Social Distancing and Mental Health Knowledge & Access scales. Respondents who had seen "Coach John" scored significantly higher on the Lack of Social Distancing scale.

Of Hispanic respondents, those who had seen "Luis" scored significantly lower on the Mental Health Openness and Mental Health Knowledge & Access scales. Mean scores are detailed in Table 1 below.

Table 1. Scale scores for respondents who reported that they had previously seen the spot (Yes), or had never seen the spot (No). Only Hispanic respondents were asked whether they had seen the Spanish-language spots (Luis and Pedro).

	Bill & Doug		Tyler		Older Adult		Coach John		Luis		Pedro	
Scale	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Lack of Social Distancing	2.73*	2.61	2.74*	2.61	2.70*	2.61	2.72*	2.62	2.62	2.62	2.59	2.62
Mental Health Openness	2.88	2.95	2.89	2.94	2.92	2.94	2.93	2.93	2.69	2.93*	2.79	2.90
Mental Health Literacy	3.41*	3.32	3.37	3.33	3.35	3.34	3.36	3.34	3.17	3.27	3.21	3.25
Mental Health Knowledge & Access	2.93*	2.79	2.98*	2.78	2.89*	2.78	2.87	2.81	2.69	2.89*	2.70	2.87

* Indicates statistical significance

Treatment History and Community Needs

Respondents were asked about their mental health treatment history. As can be seen in Table 2 below, more respondents reported having received treatment either currently, or in the past at Wave II than at Wave I. However, the same number of respondents reported knowing someone who was currently receiving treatment, which is a non-stigmatizing response. More HSRC respondents indicated that they knew someone currently receiving treatment for mental health problems, that they were currently receiving treatment themselves, or that they had received treatment in the past than respondents in the concurrent Wave II of the Strata survey.

While the Strata survey always asked the treatment questions before questions about the media campaign, HSRC asked them after respondents were exposed to the It's Up to Us spots. The increase in reporting rate could be attributed to a reduction in stigma caused by viewing the spots.

Reports of current and previous treatment for mental health problems were compared for respondents who had, and had not seen the It's Up to Us ads.

- Respondents who had seen at least one of the It's Up to Us ads were significantly more likely to report having ever received treatment for mental health problems than those who did not recognize any of the ads
- Respondents who had seen at least one of the ads were more likely to report having thought about seeking help in the past 6 months and to have sought help in the past 6 months

When looking at only Hispanic respondents, compared to respondents who had not seen the spot:

- Hispanic respondents who had seen "Luis" or "Pedro" were more likely to know someone who is currently getting treatment for mental health problems, and to have personally received treatment in the past
- Hispanic respondents who had seen "Pedro" were also more likely to be currently receiving treatment for a mental health problem

This increase could indicate an increase in help-seeking behavior, however, that cannot account for the finding that respondents were more likely to report receiving treatment more than a year prior, since the campaign was only in place for six months. The change in reporting could also be due to respondents feeling less stigmatized about their treatment history, which would correspond to the increase found on the Mental Health Openness scale.

Table 2. Comparison of reported treatment history for respondents in the HSRC and Strata surveys.

	Strata—Wave I		Strata—Wave II		HSRC—Direct Exposure	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
Know anyone receiving MH treatment	47.6%	52.4%	47.8%	52.2%	57%	43%
Currently receiving MH treatment	11.6%	88.4%	14.0%	86.0%	17.5%	82.5%
Previously had MH treatment	14.8%	85.2%	18.0%	82.0%	24.7%	75.3%

Campaign Exposure

With prompting, **59% of respondents recalled at least one It's Up to Us spot**.

The following messages about mental health were most frequently recalled:

- Depression is not a normal part of aging—40%
- Mental health challenges affect 1 in 4 adults—39%
- Mental health is part of your overall health—39%
- One friend reaching out makes all the difference—35%
- It's Up to Us—25%
- Get help—25.8%
- Contact a crisis hotline—25.2%
- Every day people recover from mental illness—24%
- Depression—21.4%
- Suicide Prevention—17.7%

After listening to each spot, respondents answered mental health literacy and acceptance questions to determine which spots had the greatest positive influence (see Table 3).

- Each ad showed increases in literacy and acceptance
- "Tyler" showed the greatest increase in each of the literacy items, and in three of the acceptance items

Table 3. Effects of direct exposure to each of the ads on respondents' mental health literacy and stigmatizing behavior.

	Coach John	Bill & Doug	Older Adults	Tyler
Listening to this ad…		**% Agree or Strongly Agree**		
Helped you recognize symptoms of mental health problems[2]	48.0%	64.5%	75.2%	76.1%
Helped you recognize warning signs of suicide[2]	29.7%	43.8%	37.2%	42.1%
Gave you information on how to get help[2]	75.2%	79.3%	83.5%	83.5%
How did this ad affect your likelihood to…		**% Very much or Somewhat**		
Be as supportive as possible to someone experiencing MI[1]	76.7%	74.1%	83.5%	59.5%
Make an effort to find out more about MI[2]	59.1%	63.8%	65.8%	69.3%
Treat others who have MI with respect[2]	79.3%	73.7%	84.2%	86.1%
Feel comfortable talking to a friend or family member about their MI[2]	67.2%	73.0%	76.3%	78.1%

[1] "Older Adults" had the greatest impact on this item; [2] "Tyler" had the greatest impact on these items.

Wave II Results

Analyses demonstrated a significant impact on residents of San Diego County. **Thirty-six percent of people who viewed a campaign spot had discussed it with someone else.** The spots, which encourage individuals to seek help, resulted in over 500 calls to the ACL lines in the first six months of the campaign.

San Diegans who were exposed to the It's Up to Us campaign:

- Scored significantly higher on the Lack of Social Distancing and Mental Health Knowledge & Access scales indicating reduced stigma and increased knowledge of mental health resources
- Were more comfortable talking to a friend or family member about their mental health
- Were more likely to know how to recognize warning signs for suicide, and where to get help for someone showing warning signs of suicide
- A significantly larger proportion of respondents in Wave II compared to Wave I reported that if they were suffering from a mental illness they would seek help from family or friends, a medical doctor, a counselor or psychologist, a crisis line, a spiritual leader, a website, or an employer.

Results from these early analyses demonstrate specific areas that the media campaign can focus on over the next several years, including specific target populations, and additional mental health topics. Ongoing education about mental health can help dispel some of the myths about mental illness, inform people about available resources, and make people more comfortable seeking help.

The HEALTH SERVICES RESEARCH CENTER at University of California, San Diego is a non-profit research organization within the Department of Family and Preventive Medicine. HSRC works in collaboration with the Performance Outcomes and Quality Improvement Unit of San Diego County Mental Health Services to evaluate and improve mental health outcomes for County residents. Our research team specializes in the measurement, collection and analysis of health outcomes data to help improve health care delivery systems and, ultimately, to improve client quality of life.

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PEER2PEER FAMILY SUPPORTLINE (PS01)

MENTAL HEALTH SYSTEMS INC.

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

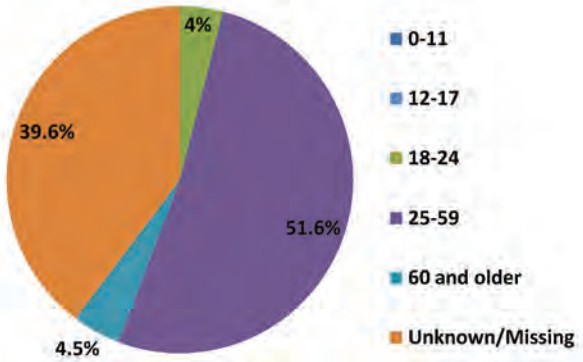
REGION: NORTH CENTRAL- DISTRICT 4

Peer2Peer provides non-crisis, confidential, telephone peer-counseling services to youth and families in San Diego County. The Family Supportline is staffed by caretakers who have children who have been involved with the mental health system. The staff provide culturally-competent information, support, and referrals to needed resources. Services are provided during late afternoons and evenings for a minimum of five days per week. A licensed supervising clinician is available for four hours per week to provide consultation on handling complex phone contacts. *Participant responses to demographics and satisfaction questions were reported to an automated telephone system. Therefore, data for this program are reported in a different manner from other programs.*

CONTRACTOR:	Mental Health Systems Inc.		
CONTRACT START DATE:	5/10/2010	**DATA COLLECTION START DATE:**	7/1/2010
PROGRAM SERVICES START DATE:	5/17/2010	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	810	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	810

CAREGIVER DEMOGRAPHICS

AGE

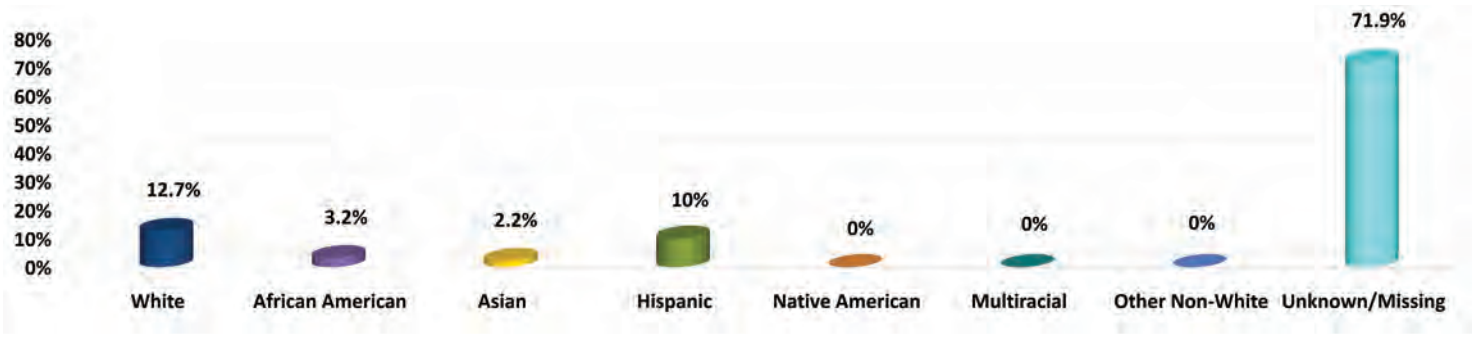


More than half of the callers were ages 25-59; however, approximately 40% did not report their age.

GENDER

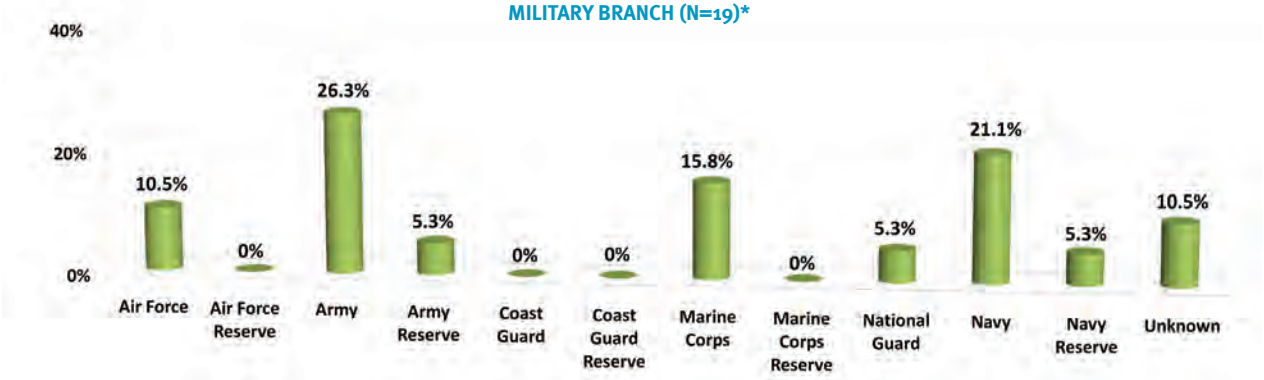
About half of the callers did not report their gender. Approximately 39% of the callers reported they were female; 12% of callers reported they were male.

RACE/ETHNICITY



The majority of the callers (72%) did not identify their ethnic background. Approximately 13% of callers identified their ethnic background as White and 10% of callers identified their ethnic background as Hispanic. Of those identifying as Hispanic, the majority identified as Mexican American.

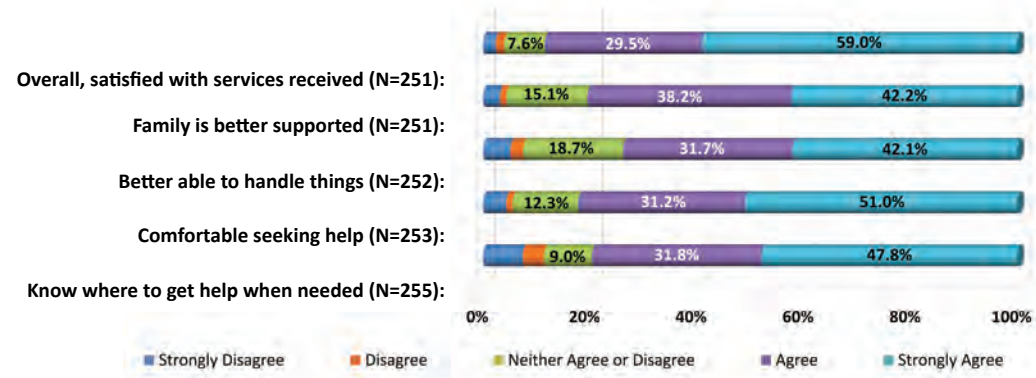
MILITARY SERVICE



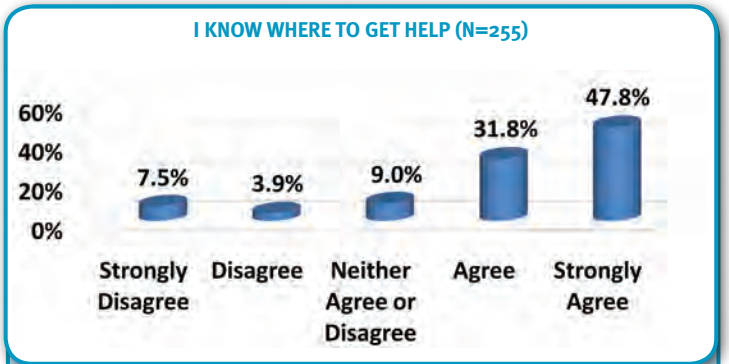
Callers were asked in which branch of the military the youth's caregiver had served. Of the 19 who responded, 5 (26%) reported that the caregivers were in the Army, and 4 (21%) reported that the caregivers were in the Navy.

**Caregivers could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION

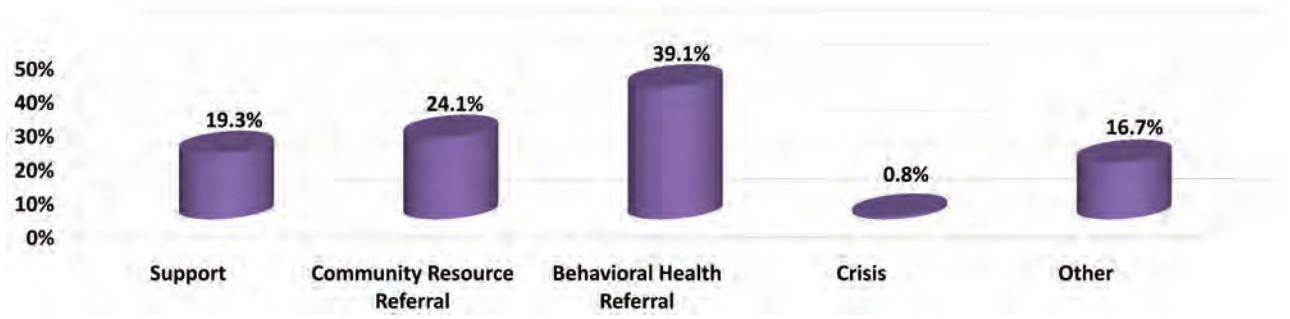


The majority of callers did not respond to program satisfaction questions. Of those who did respond, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 89% of the callers who responded were satisfied with the services received.



The majority of callers responding to this question reported that they knew where to get help when they needed it. Approximately 11% did not agree with this statement.

FAMILY SUPPORTLINE TYPE OF CALL (N=810)

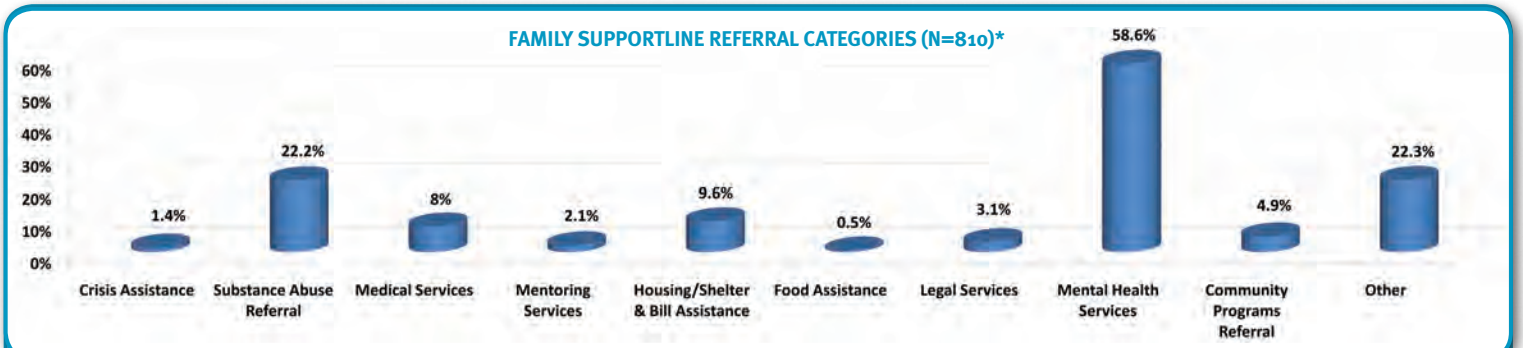


The majority (39%) of Family Supportline calls were classified as behavioral health referrals. Additionally, 24% of calls were community resource referrals. The remaining topics were support (19%), crises (1%) and other topics not specified (17%).

FAMILY SUPPORTLINE CALL LANGUAGE (N=810)

The majority (86%) of calls transpired in English. The remaining 10% of calls took place in Spanish.

FAMILY SUPPORTLINE REFERRAL CATEGORIES (N=810)*



The majority of callers received referrals for mental health services (59%) and substance abuse services (22%). Approximately 22% received referrals for services other than those categorized above.

**Some callers may receive referrals to more than one type of program so percentages may add up to more than 100% .*

The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

PEER2PEER YOUTH TALKLINE (PS01)

MENTAL HEALTH SYSTEMS INC.

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

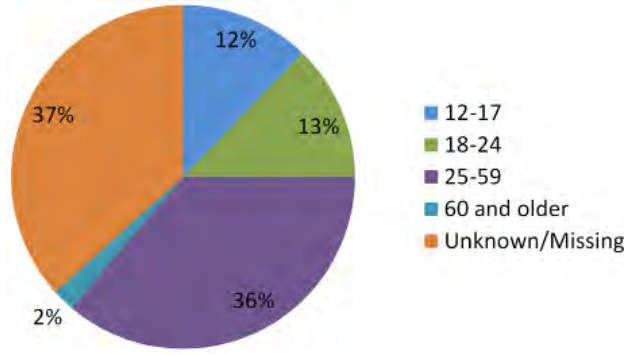
REGION: NORTH CENTRAL- DISTRICT 4

Peer2Peer provides non-crisis, confidential, telephone peer-counseling services to youth and families in San Diego County. The Youth Talkline is staffed by youth who have prior experience with the mental health system. The staff provide culturally-competent information, support, and referrals to needed resources, as well as appropriate services. Services are provided during late afternoons and evenings for a minimum of five days per week. A licensed supervising clinician is available for four hours per week to provide consultation on handling complex phone contacts. *Participant responses to demographics and satisfaction questions were reported to an automated telephone system. Therefore, data for this program are reported in a different manner from other programs.*

CONTRACTOR:	Mental Health Systems Inc.		
CONTRACT START DATE:	5/10/2010	**DATA COLLECTION START DATE:**	7/1/2010
PROGRAM SERVICES START DATE:	5/17/2010	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	188	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	188

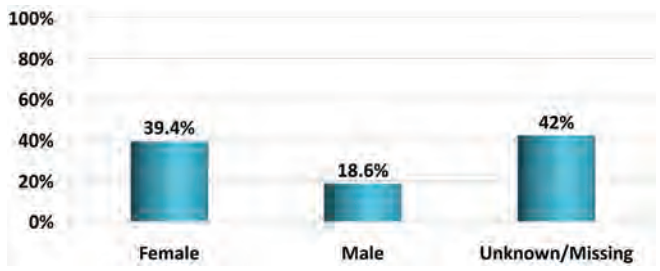
YOUTH DEMOGRAPHICS

AGE



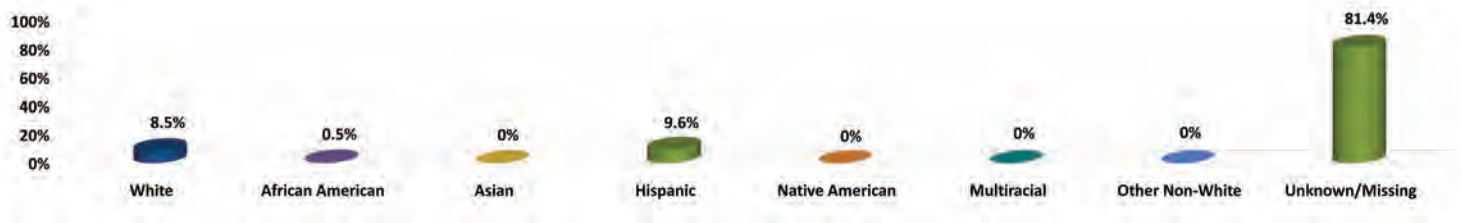
Thirty-seven percent of the population served did not report their age. More than one-third were ages 25-39, and one quarter were adolescents and young adults ages 12-24.

GENDER



Forty-two percent of callers did not report their gender. Almost 40% of the callers receiving services were female; 19% of callers were male.

RACE/ETHNICITY

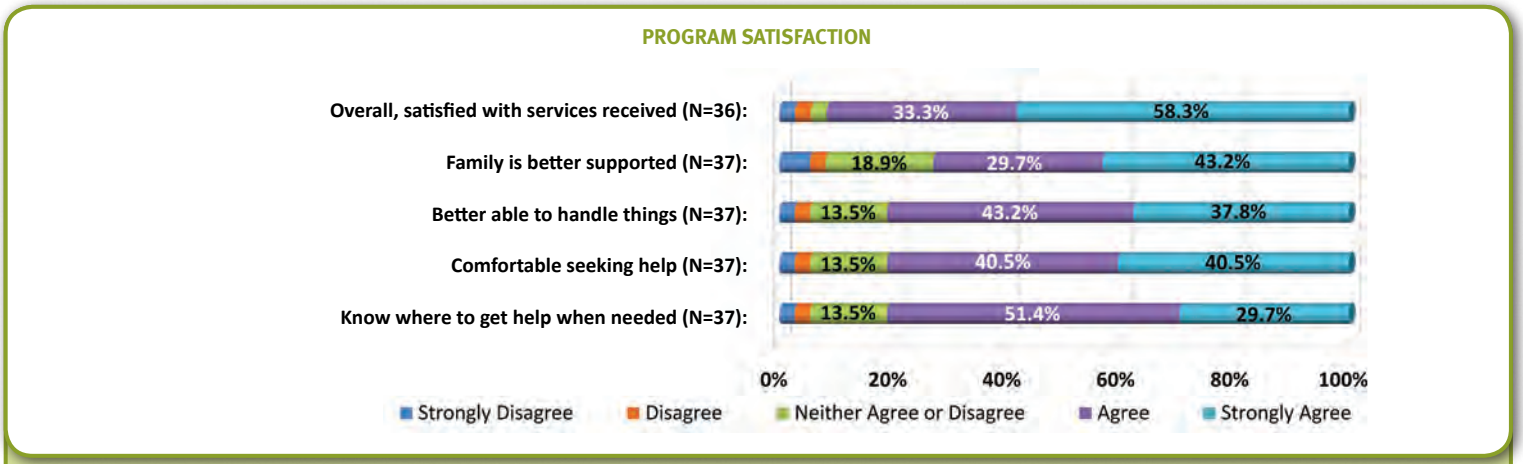


Almost 82% of the callers did not identify their ethnic background. Approximately 10% of the callers identified their ethnic background as Hispanic and 9% of the callers identified their ethnic background as White. Of those identifying as Hispanic, the majority (94%) identified as Mexican American.

MILITARY SERVICE

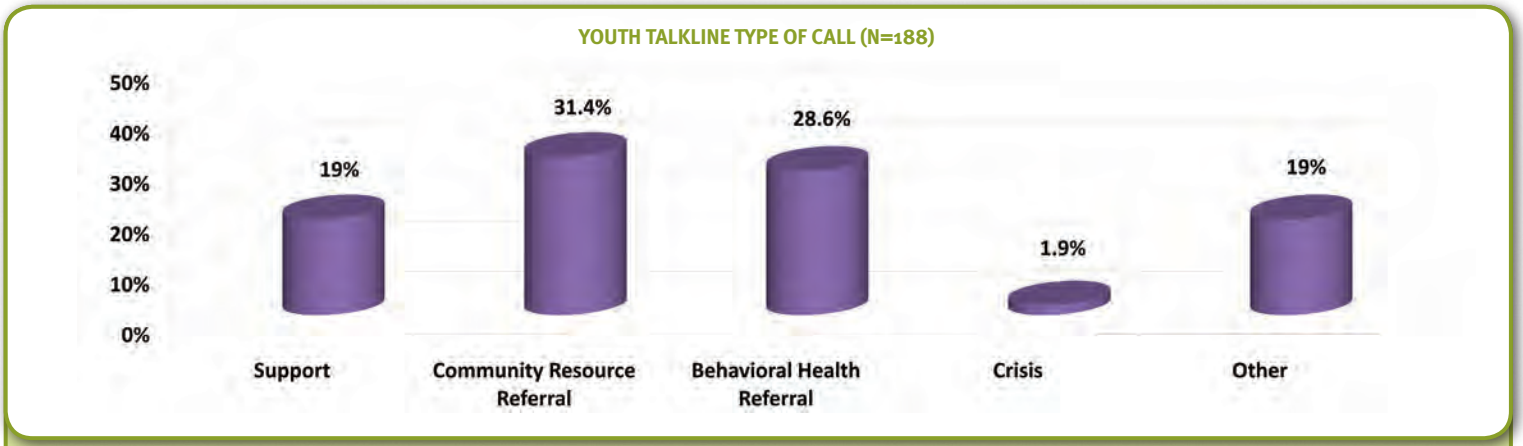
Callers were asked in which branch of the military the youth's caregiver had served. Of the 2 who responded, both reported that the caregivers were in the Marine Corps.

PROGRAM SATISFACTION



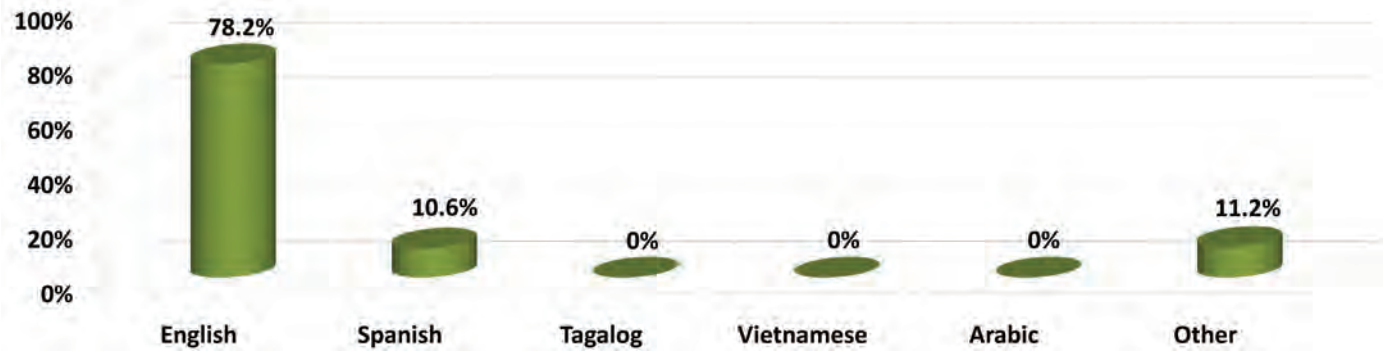
The majority of callers did not respond to program satisfaction questions. Of those who did respond, most agreed that they were better able to handle things and solve problems as a result of the services. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 92% of the callers who responded to these questions were satisfied with the services received.

The majority of the callers responding to this question reported that they knew where to get help when they needed it. Approximately 5% did not agree with this statement.



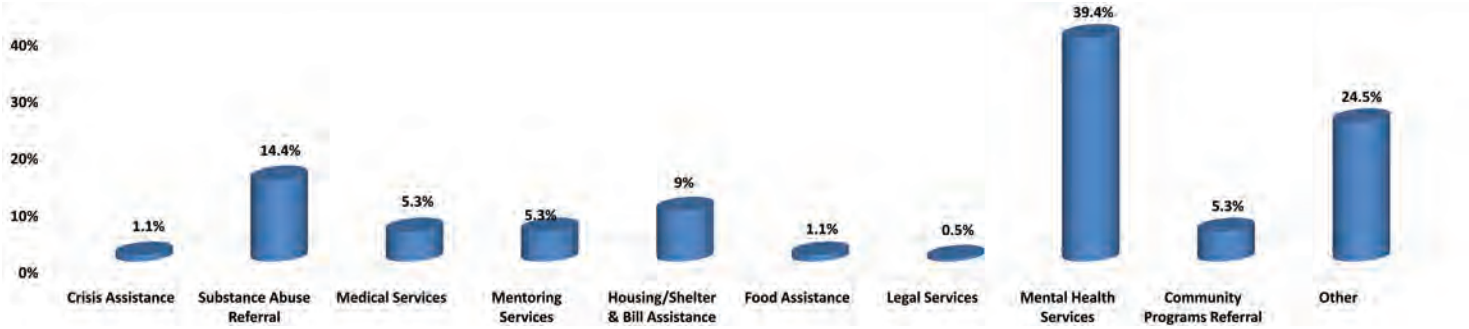
Roughly one-third of Youth Talkline calls were classified as community resource referrals (31%) and behavioral health referrals (29%). The remaining third consisted of calls relating to support, crises, or other topics.

YOUTH TALKLINE CALL LANGUAGE (N=188)



The majority of the calls transpired in English (78%). Eleven percent of the calls took place in Spanish. The call language was not reported for approximately 11% of the calls.

YOUTH TALKLINE REFERRAL CATEGORIES (N=188)*



The majority of the callers who received referrals were referred to mental health services (39%). Roughly 25% of callers received referrals for services other than those categorized above.

**Some callers may receive referrals to more than one type of program so percentages may add up to more than 100%.*

The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

FAMILIES AS PARTNERS (DV01)

SOUTH BAY COMMUNITY SERVICES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

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CASRC child and adolescent services research center

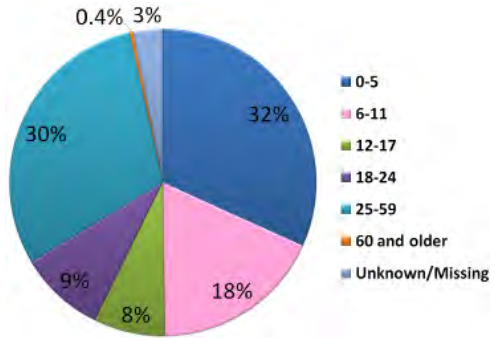
REGION: SOUTH- DISTRICT 4

Families as Partners (FAP) is a San Diego South Region partnership between families, Child Welfare Services, and community service providers. The goal of the partnership is to establish a community safety net for the well-being of the South Region's children and their families who are at risk of becoming involved in the child welfare system. Families are referred from the child welfare hotline, and FAP provides services immediately to help them maintain a safe home and reduce the effects of trauma exposure. FAP clinicians visit families in their homes, conduct thorough assessments of the families' needs and strengths, and help families connect with resources in their community. In some cases, families receive information and support from Parent Peer Partners, parents with former experience with the child welfare system. Families also participate in team decision-making meetings (TDM) with the FAP team, and help develop safety plans for their children.

CONTRACTOR:	South Bay Community Services		
CONTRACT START DATE:	5/1/2009	**DATA COLLECTION START DATE:**	5/1/2009
PROGRAM SERVICES START DATE:	5/1/2009	**REPORT PERIOD:**	7/1/2010—6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	255 unduplicated	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	550 (may include duplicates)

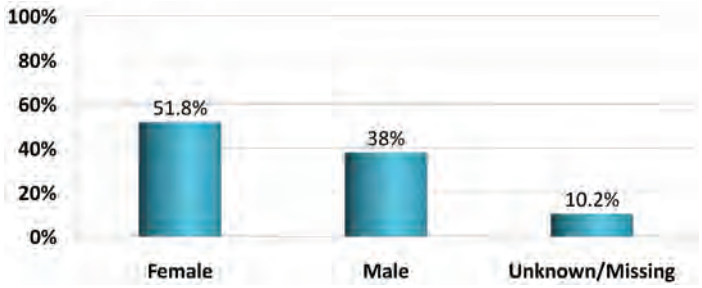
YOUTH AND CAREGIVER DEMOGRAPHICS

AGE



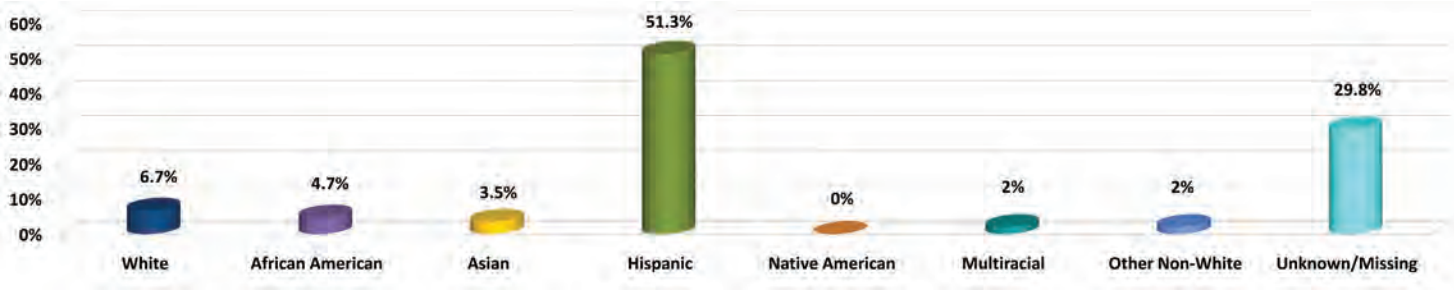
Children and youth ages 0 to 11 comprised 50% of the population served.

GENDER

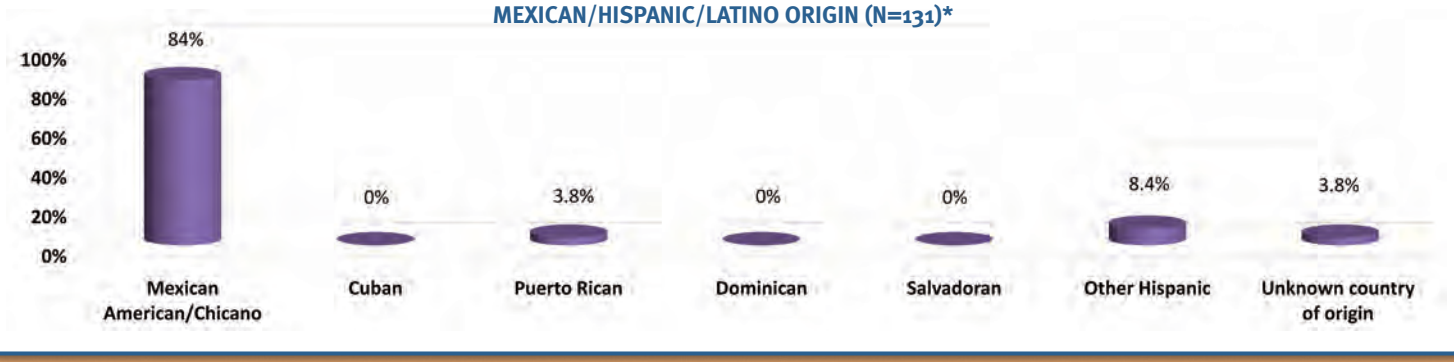


More than half of the participants who received services were female.

RACE/ETHNICITY



More than half of participants who received services identified their ethnic background as Hispanic. However, roughly one-third of all participants served did not report their race.



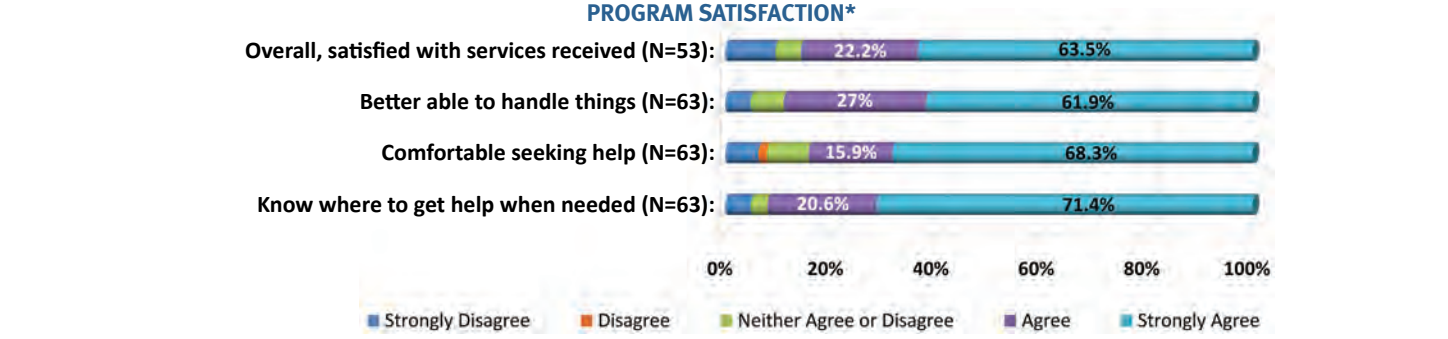
The majority of the Hispanic population served identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

MILITARY SERVICE

Of the 251 participants who responded to this question, the majority (98%) reported that the youth's caregiver had not served in the military. Of the four caregivers who had served in the military, three served in the Navy and one served in an unspecified branch.

PROGRAM SATISFACTION



The majority of participants did not respond to program satisfaction questions. Of those who did respond, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 86% of the participants who responded were satisfied with the services received.

**Satisfaction data not available for all participants.*

More than 90% of participants who responded to this question reported that they knew where to get help when they needed it.

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SOUTH REGION TRAUMA EXPOSED SERVICES (DV02)

FRED FINCH YOUTH CENTER

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

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CASRC child and adolescent services research center

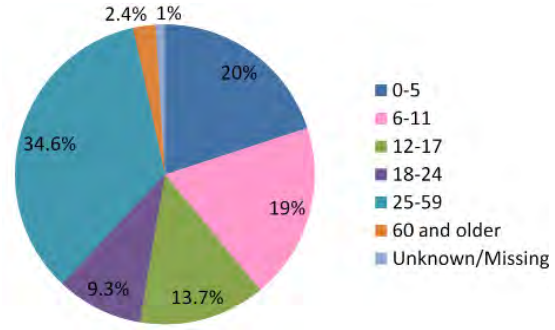
REGION: SOUTH - DISTRICT 1

The Fred Finch Youth Center (FFYC) Triple P Positive Parenting Program is an evidence-based, comprehensive prevention and early intervention program to help prevent re-traumatization of children and families who experience contact with the child welfare system. The program serves children and their families that recently had involvement with Child Welfare Services, but do not require voluntary or dependent services. However, Child Welfare Services deems that these families could benefit from parenting and/or support in order to prevent further child welfare involvement. The Triple P Program helps parents develop stronger parenting skills and effectively manage child misbehavior.

CONTRACTOR:	Fred Finch Youth Center		
CONTRACT START DATE:	7/1/2010	**DATA COLLECTION START DATE:**	1/1/2011
PROGRAM SERVICES START DATE:	1/1/2011	**REPORT PERIOD:**	7/1/2010—6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	205 unduplicated	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	205

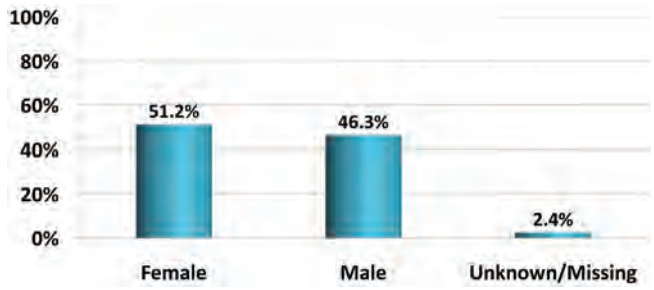
YOUTH AND CAREGIVER DEMOGRAPHICS

AGE



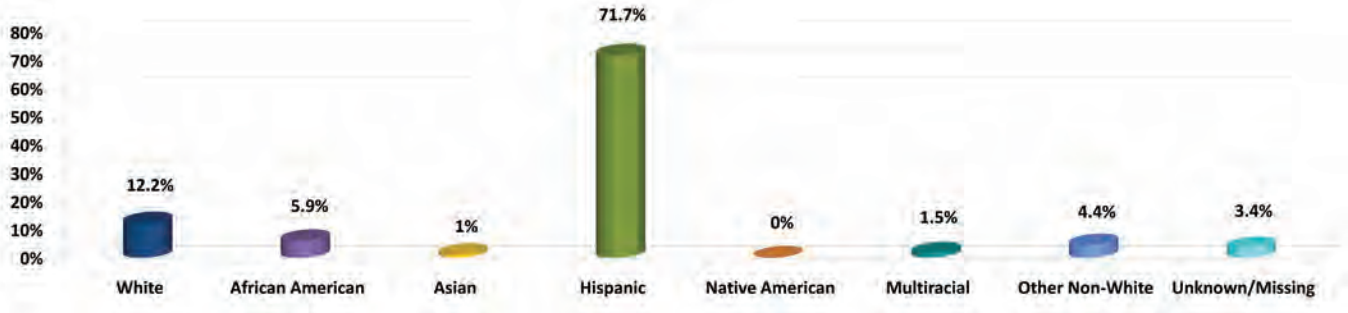
Children and youth ages 0 to 17 comprised more than half of the population served.

GENDER

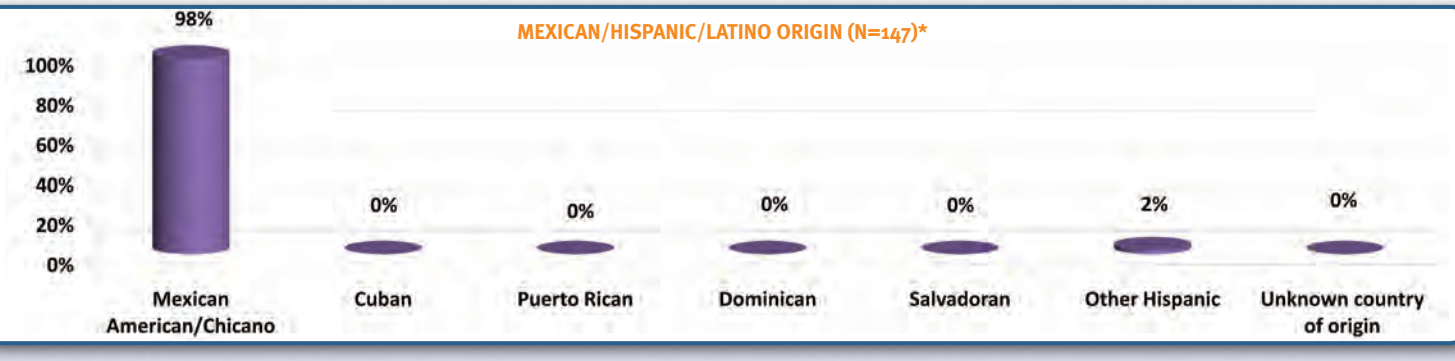


The program served slightly more female than male participants.

RACE/ETHNICITY



Over 70% of participants receiving services identified their ethnic background as Hispanic.



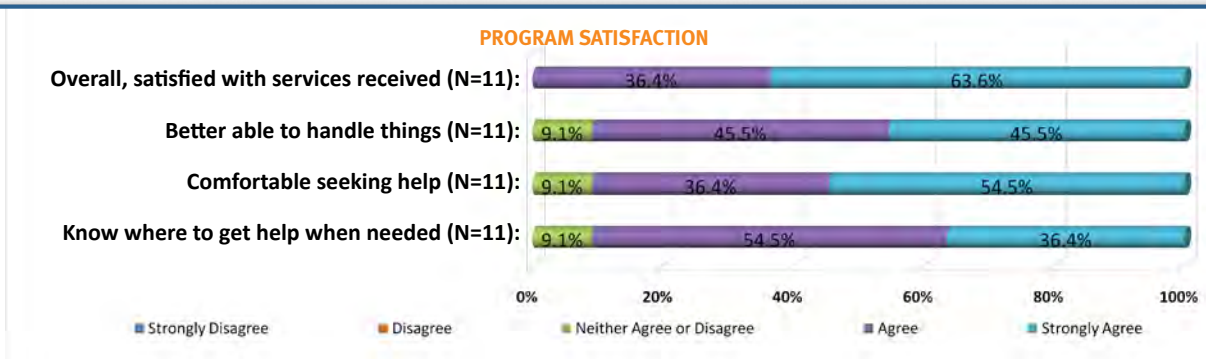
The majority of the Hispanic population served identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

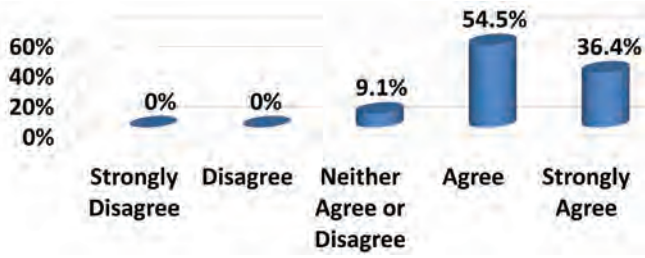
MILITARY SERVICE

Of 204 participants who responded to this question, 99% reported that the youth's caregiver had not served in the military. Of the three caregivers who had served in the military, two served in the Navy and one served in an unspecified branch.

PROGRAM SATISFACTION



The majority of participants did not respond to program satisfaction questions. Of those who did respond, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 100% of the participants who responded were satisfied with the services received.



The majority of participants who responded to this question reported that they knew where to get help when they needed it.

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ALLIANCE FOR COMMUNITY EMPOWERMENT (DV03)

UNION OF PAN ASIAN COMMUNITIES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

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CASRC child and adolescent services research center

REGION: CENTRAL- DISTRICT 4

The Alliance for Community Empowerment (ACE) provides five different PEI programs that help prevent community violence and support families in San Diego: the Community Violence Response Team, Parent and Youth Gang Awareness groups, Leadership Academy and Strengthening Families program. The Community Violence Response Team provides assistance to individuals who are impacted by acts of violence. The gang awareness groups teach both caregivers and youth about the risk factors for gang involvement, and the Leadership Academy is an on-going intervention designed to help prevent 12-16 youth from participating in gangs. This intervention teaches youth how to improve their decision-making skills and handle peer pressure. The support groups help community members who are grieving the loss of loved ones, many of whom were victims of violence. Finally, the Strenthening Families Program is a researched-based intervention that provides training in parenting, communication, and problem-solving skills to increase families' resilience and reduce the risk of substance abuse, delinquency, and school failure.

CONTRACTOR:	Union of Pan Asian Communities (UPAC)		
CONTRACT START DATE:	12/1/2009	**DATA COLLECTION START DATE:**	1/4/2010
PROGRAM SERVICES START DATE:	1/4/2010	**REPORT PERIOD:**	7/1/2010—6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	452 unduplicated [1,2]	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	576 unduplicated families[3]

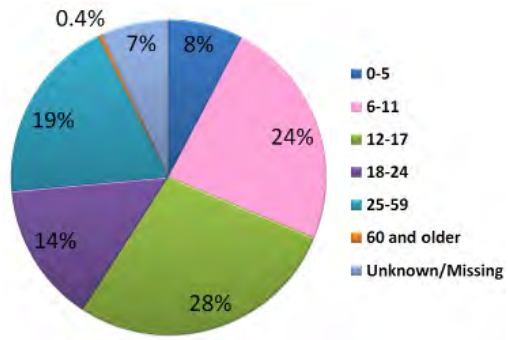
1. Data are limited to information entered into HOMS as of 10/31/2011. Data are not available for the Strengthening Families Program.

2. Demographics are only available for 284 individuals who received community violence response services.

3. This information comes from the QSR for Q4 FY10-11.

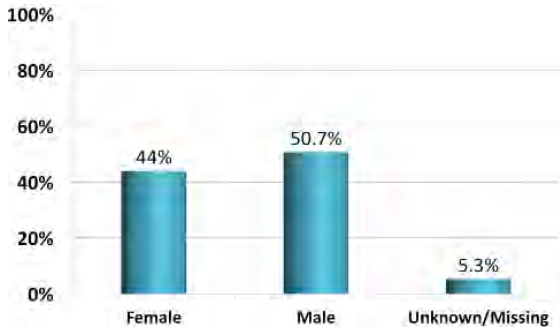
DEMOGRAPHICS OF INDIVIDUALS SERVED BY THE COMMUNITY VIOLENCE RESPONSE TEAM

AGE



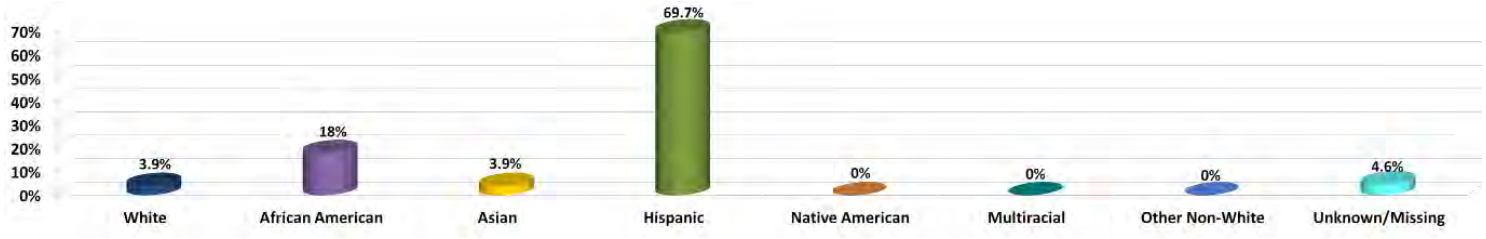
Children and adolescents ages 0 to 17 comprised 60% of the population served.

GENDER



Approximately half of the participants who received services were male.

RACE/ETHNICITY



Roughly 70% of participants who received services identified their ethnic background as Hispanic.

REFERRALS TO ACE'S PEI PROGRAMS

REFERRALS*	N
Number of clients referred to ACE PEI programs	126
Number of referred clients who attended ACE PEI programs	60

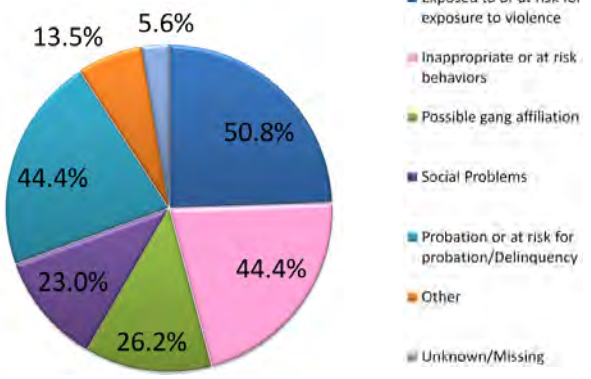
** Data not available for all clients.*

GROUP PROGRAMS

ATTENDANCE AT ACE GROUP PROGRAMS	N
Gang Awareness- Parent	91
Gang Awareness- Youth	49
Strengthening Families*	--
Leadership Academy	81
Support Groups	27

** Data not available.*

REASONS FOR REFERRALS*

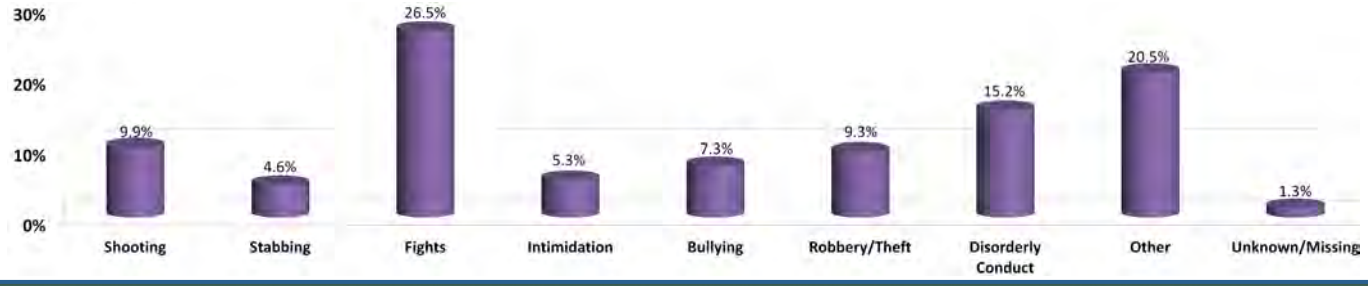


The majority of referrals were for individuals who had been exposed to or were at risk for exposure to violence.

**Participants can be referred for multiple reasons so percentages may add up to more than100%.*

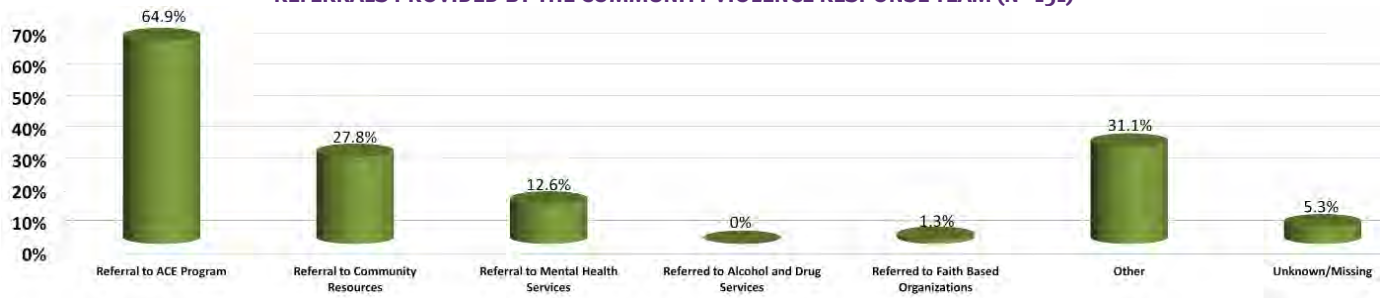
COMMUNITY VIOLENCE RESPONSE TEAM

COMMUNITY VIOLENCE INCIDENT TYPE (N=151)



The most common type of incident the Community Violence Response Team responded to was a fight.

REFERRALS PROVIDED BY THE COMMUNITY VIOLENCE RESPONSE TEAM (N=151)*



The majority of referrals provided by the community violence response team were referrals to ACE programs.

** Participants can be referred to more than one service so percentages may add up to more than 100%.*

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POSITIVE PARENTING PROGRAM—TRIPLE P (EC01)

JEWISH FAMILY SERVICES (JFS)

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

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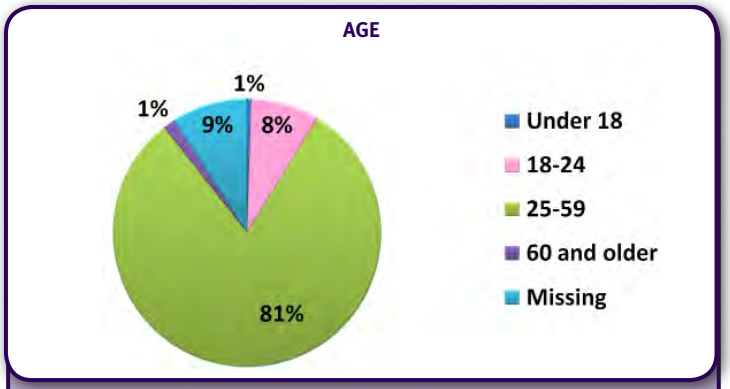
REGION: NORTH CENTRAL - DISTRICT 4

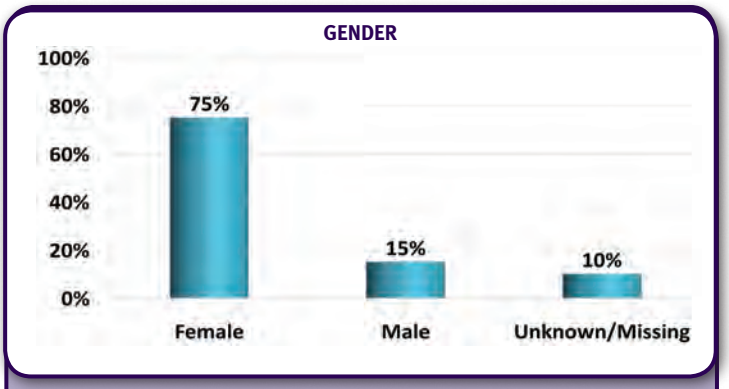
The Triple P – Positive Parenting Program serves Head Start (HS) and Early Head Start (EHS) Centers to strengthen the skills of parents, HS/EHS center staff, and educators in order to promote the development, growth, health, and social competence of young children. Services are designed to benefit the child by teaching caregivers and Head Start staff specific parenting skills and techniques for managing misbehavior. This Triple P program provides both group-based trainings and individual treatment. Staff are also trained to provide ongoing support to the family/caregiver once the Triple P curriculum is completed. This program serves the Central and North Coastal regions of San Diego. This report focuses on parent outcomes.

CONTRACTOR:	Jewish Family Services		
CONTRACT START DATE:	9/1/2009	**DATA COLLECTION START DATE:**	Outcomes: 9/29/2009 PEI Demographics: 1/03/2010
PROGRAM SERVICES START DATE:	9/29/2009	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	1281	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	2545

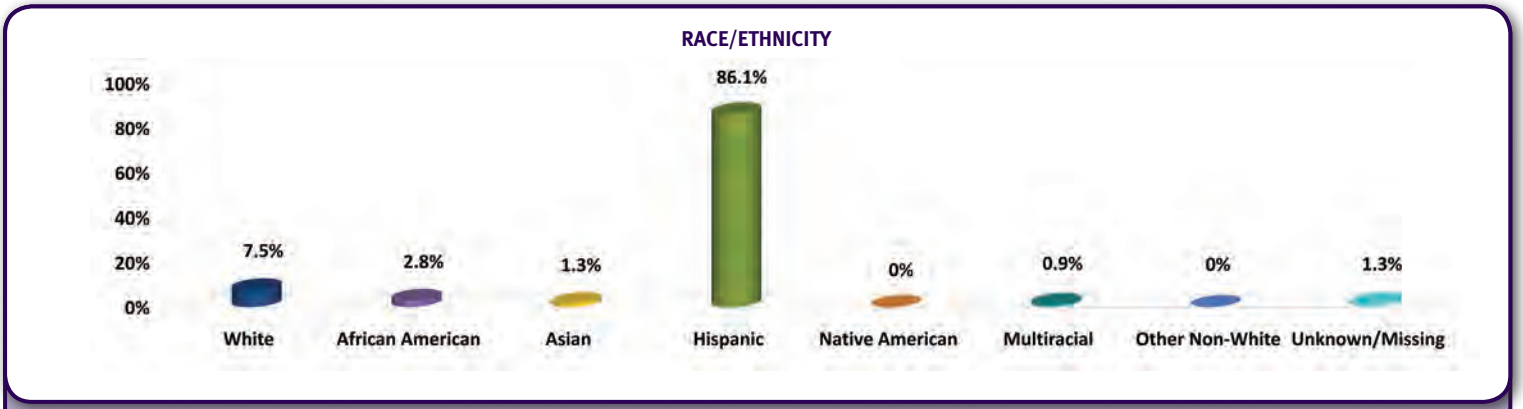
PARENT DEMOGRAPHICS



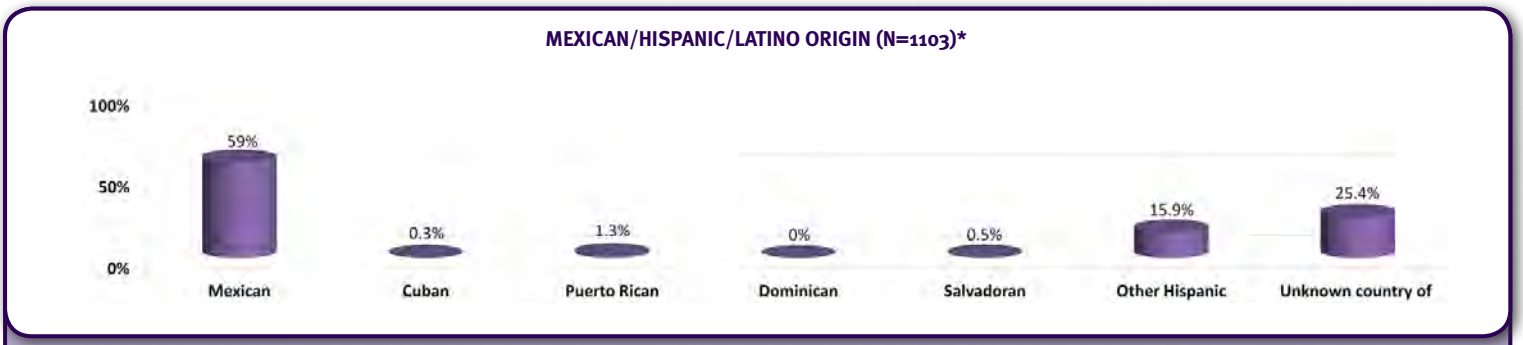
The majority of the adults served were ages 25-59 (81%). Young adults 18-24 comprised 8% of the population served.



Three quarters of the participants who received services were female.



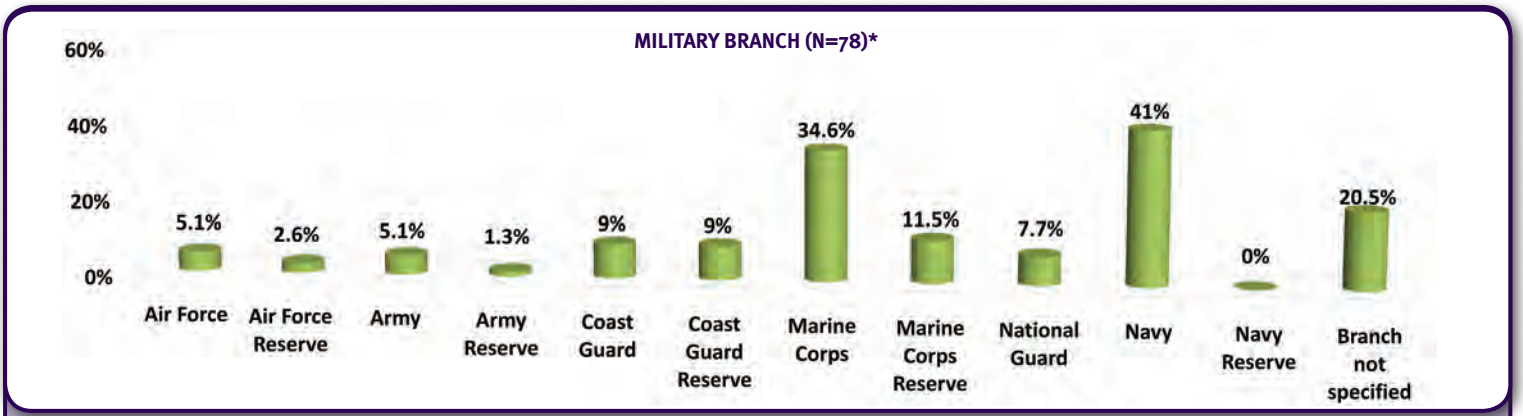
More than 85% of participants who received services identified their ethnic background as Hispanic. Roughly 8% of all participants served identified their ethnic background as White. The remaining racial/ethnic categories were not highly represented.



The majority of the Hispanic population served identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

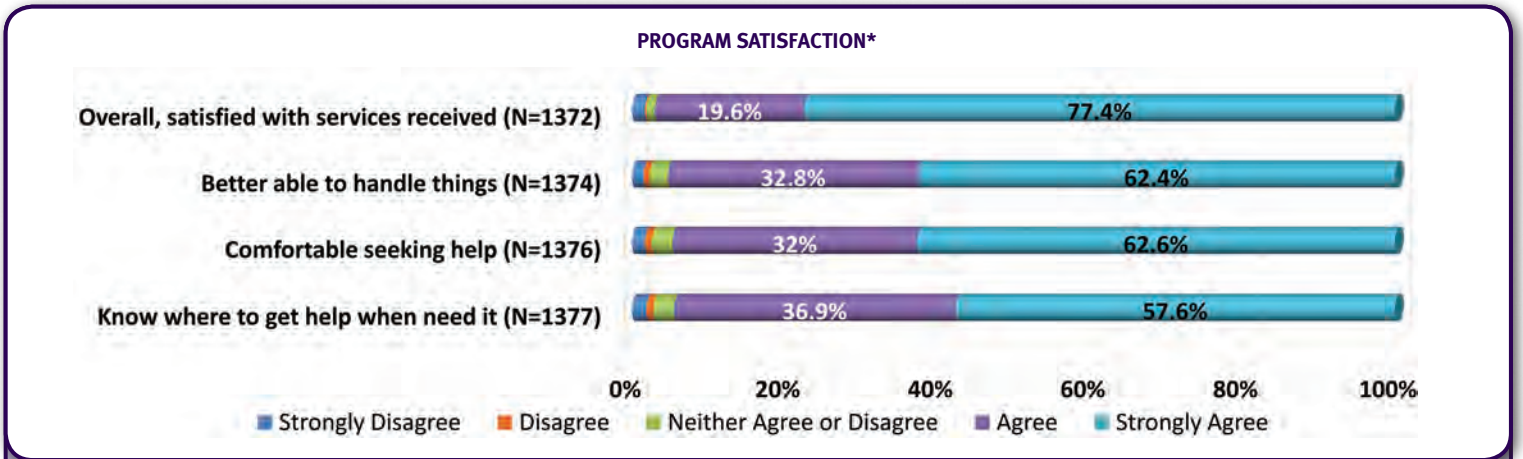
MILITARY SERVICE



Of the 1163 participants who responded to this question, 93% reported that caregivers had not served in the military. Of the 78 clients that reported caregivers had served in the military, 32 (41%) caregivers served in the Navy, 27 (35%) served in the Marine Corps. Sixteen (21%) served in an unspecified branch.

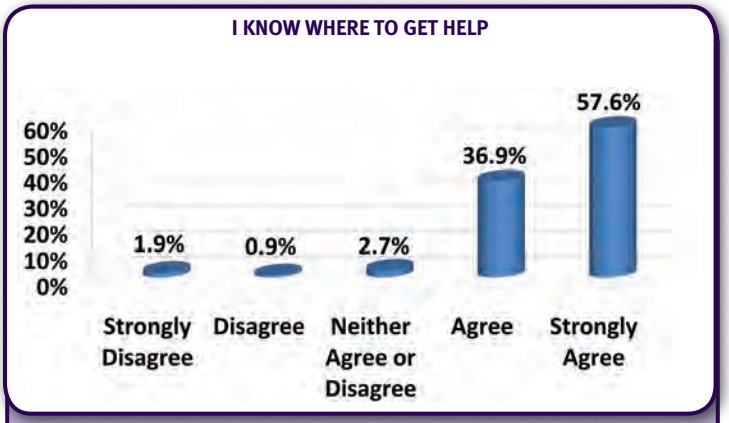
** Participants could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



Most participants responding to these questions agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 97% of the participants were satisfied with the services received.

** Satisfaction data includes duplicated participants.*



The majority of participants responding to this question reported that they knew where to get help when they needed it. Approximately 3% did not agree with this statement.

"I know where to get help when I need it."

PARTICIPATION IN PROGRAM COMPONENTS (N=1411)*	N
Pilot Seminar	420
Community Seminar	312
Head Start/ Early Head Start Seminar	385
Individual	107
Group	187
Total	**1411**

Attendance was greatest at the Pilot Seminars. More than 100 participants received individual treatment.

**Some participants attended more than one component .*

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KICKSTART (FB01)

PROVIDENCE COMMUNITY SERVICES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

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CASRC child and adolescent services research center

REGION: NORTH CENTRAL- DISTRICT 4

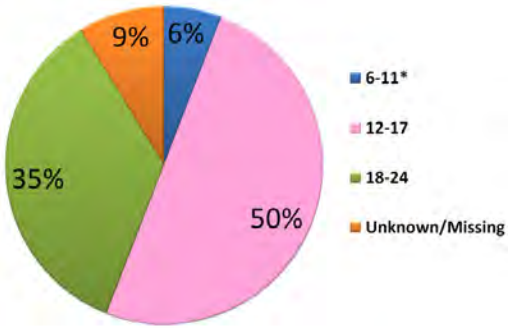
The purpose of this program is to provide prevention and early intervention services to transition-age youth (TAY) who may have prodromal symptoms of psychosis. The prevention component of the program focuses on community leaders who may have contact with TAY in general community settings. These community leaders are provided education and information on early detection of behaviors and symptoms that are risk factors for the development of psychosis. The early intervention component provides an in-depth integrated assessment for potential mental health and/or substance abuse issues, domestic/community violence, maltreatment, and physical health needs of youth who are identified as being at-risk. TAY and their families are referred and linked for further assessment by a trained clinician. Youth who screen positive for prodromal symptoms receive psycho-education classes, support services, and treatment interventions. This report focuses on the outcomes of the youths.

CONTRACTOR:	Providence Community Services		
CONTRACT START DATE:	12/1/2009	**DATA COLLECTION START DATE:**	May 2010
PROGRAM SERVICES START DATE:	4/1/2010	**REPORT PERIOD:**	7/1/2010—6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	55*	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	Community members who received gate-keep trainings: 902 Youth screened: 209 Youth enrolled: 62

**34 participants had demographic and phone screen data. 39 participants had Scale of Prodromal Symptoms (SOPS) assessment data.*

YOUTH DEMOGRAPHICS

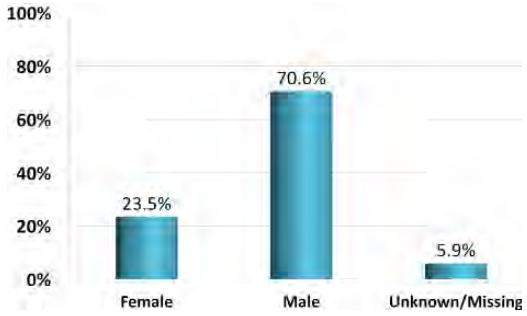
AGE



Adolescents ages 12-17 comprised 50% of the population served while TAY ages 18-24 comprised 35% of the population served.

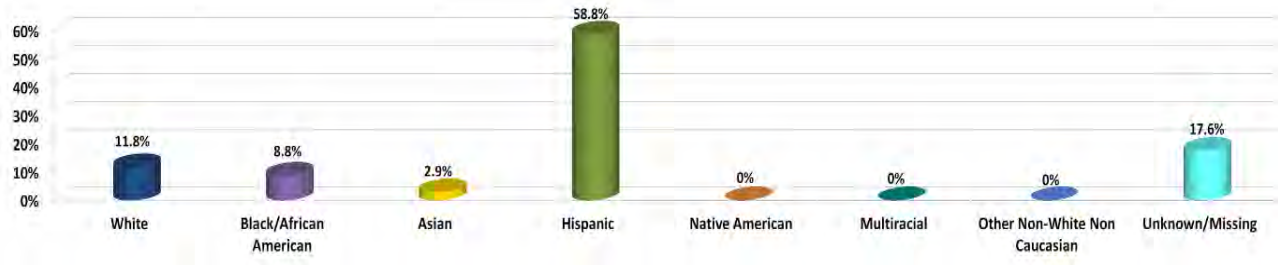
**The two youth in this age-group were screened but referred to other age-appropriate services.*

GENDER



Over 70% of the participants who received services were male.

RACE/ETHNICITY



More than half of the participants who received services identified their ethnic background as Hispanic. Roughly 18% of all participants served did not identify their race.

The majority of the Hispanic population served identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

MILITARY SERVICE

Of the 19 participants who responded to this question, 89% indicated that their caregiver had not served in the military. Only two participants reported that their caregiver had served in the military; neither identified the branch in which their caregiver served.

PARTICIPANT SYMPTOMS AT INTAKE

PHONE SCREEN SYMPTOM CHECKLIST*	%
Changes in perception (N=16) (e.g. auditory/visual/tactile/olfactory abnormalities)	81.3
Changes in speech and thinking (N=17) (e.g. odd ideas, suspiciousness, grandiosity, tangential speech)	94.1
Changes in functioning (N=17) (e.g. work/academic difficulties, social isolation)	88.2
Changes in emotions (N=17) (e.g. flat affect, depression, anxiety, mood swings, irritability)	100.0
Vegetative symptoms (N=17) (e.g. sleep difficulties, changes in appetite, somatic complaints)	94.1
Other reported changes (N=15)	40.0

The majority of the youth who were eligible for Kickstart services based on the initial screening had experienced changes in emotions, vegetative symptoms, and changes in speech and thinking.

**Of the 34 phone screens, 17 had missing or incomplete symptom checklists.*

GAF SCORES (RANGE 0–100)	MEAN (STANDARD DEVIATION)
Current GAF (N=37)	59.4 (16.2)
Highest GAF in the past year (N=33)	56.0 (13.5)

The mean current Global Assessment of Functioning (GAF) for participants was 59.4 with a standard deviation of 16.2 on a 0-100 range. The average highest GAF score in the past year was 56.

INITIAL SCALE OF PRODROMAL SYMPTOMS (SOPS) ASSESSMENT (N=39)*	MEAN (STANDARD DEVIATION)
Positive Symptoms Domain (0–30)	7.4 (6.7)
Negative Symptoms Domain (0–36)	10.3 (8.6)
Disorganization Symptoms Domain (0–24)	5.8 (4.7)
General Symptoms Domain (0–24)	5.3 (5.0)

Among the types of symptoms reported by participants, on average, negative symptoms were the most severe.

**Higher scores indicate higher severity*

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DREAM WEAVER CONSORTIUM (NA01)

INDIAN HEALTH COUNCIL

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

REGION: COUNTY-WIDE

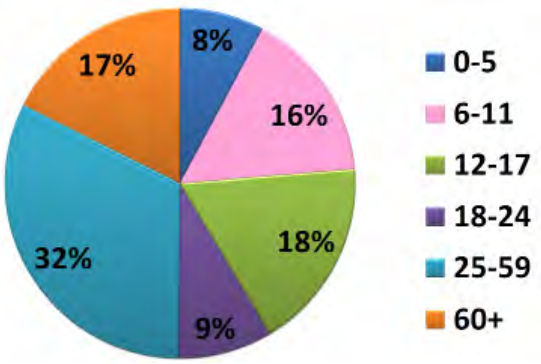
The Dream Weaver Consortium offers four different PEI programs provided by the Urban Youth Center, Indian Health Council, Southern Indian Health Council, and the Sycuan Medical/Dental Center. These providers offer prevention activities that promote community wellness and cultural awareness. Emphasis is placed on increasing awareness and access to cultural events that are known to support resilience. These services include: traditional health gatherings, cultural programs that maintain language, knowledge of basket weaving (a local tradition for many tribes), nutrition programs, self-esteem activities, male involvement strategies, positive parenting, exercise programs, and the promotion of overall increased medical and dental health. All of these services are intended to prevent the onset of serious mental health problems.

CONTRACTOR:	Indian Health Council		
CONTRACT START DATE:	4/13/2009	**DATA COLLECTION START DATE:**	April 2009
PROGRAM SERVICES START DATE:	April 2009	**REPORT PERIOD:**	7/1/2010—6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	3715 (duplicates Included)*	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	7844 (duplicates included)*

** The data presented, excluding satisfaction, were compiled from MSRs because HOMS data was unavailable. Different participant counts were reported for each variable.*

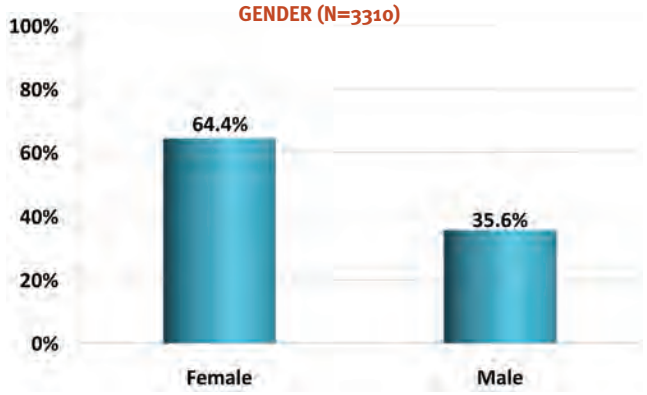
YOUTH AND CAREGIVER DEMOGRAPHICS

AGE (N=3715)



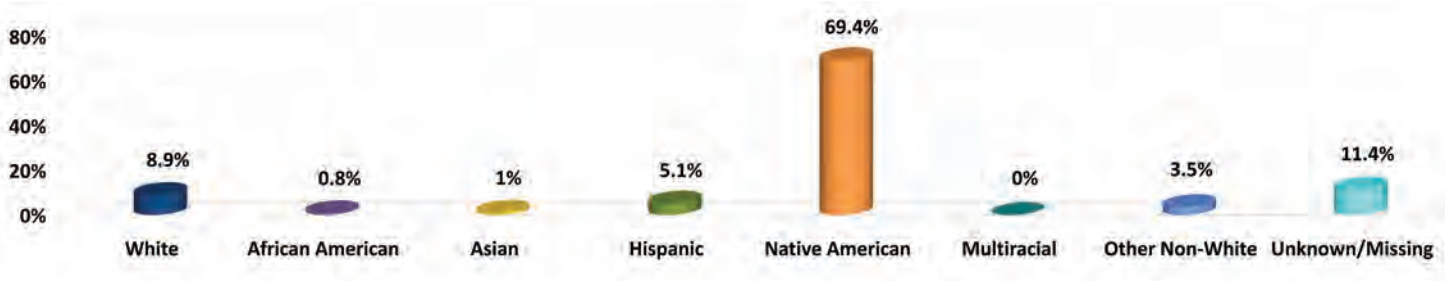
Children and youth ages 0 to 17 comprised 42% of the population served. The majority of the adults were ages 25-59 (32%).

GENDER (N=3310)



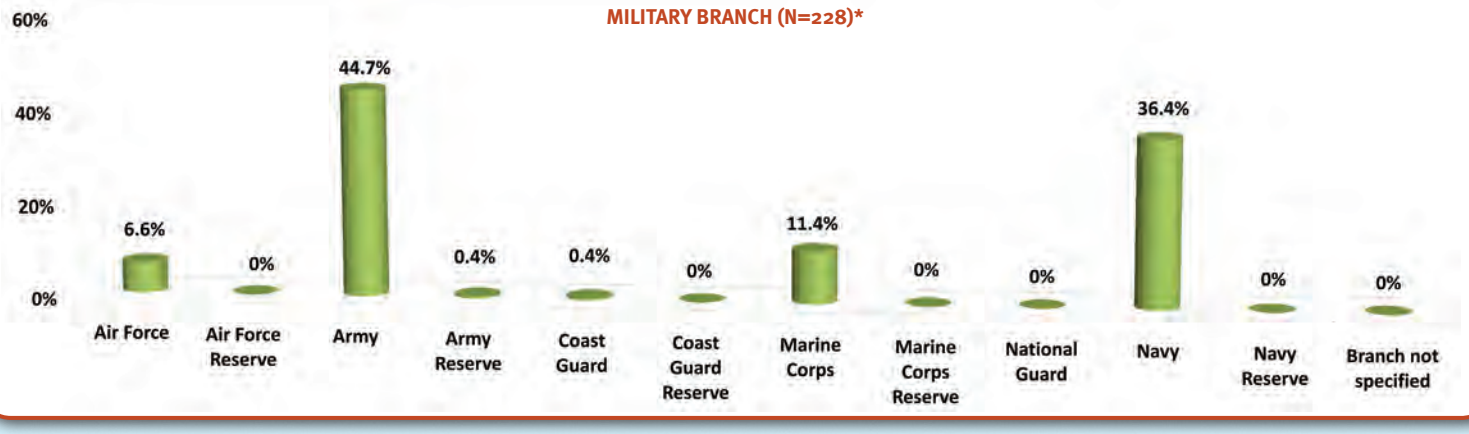
Approximately 64% of the participants who received services were female, while the remaining 36% of participants who received services were male.

RACE/ETHNICITY (N=3444)



Almost 70% of participants who received services identified their ethnic background as Native American.

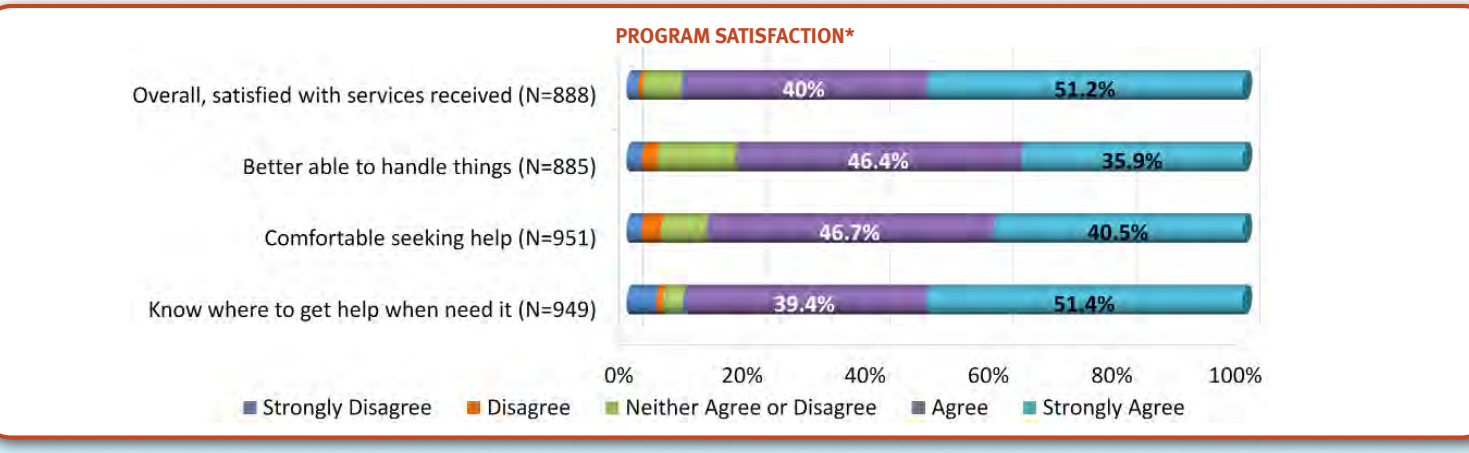
MILITARY SERVICE



Caregivers were asked in which branch of the military they had served. Of the 228 who responded, 102 (45%) served in the Army, 83 (36%) served in the Navy, 26 (11%) served in the Marine Corps and 15 (7%) served in the Air Force.

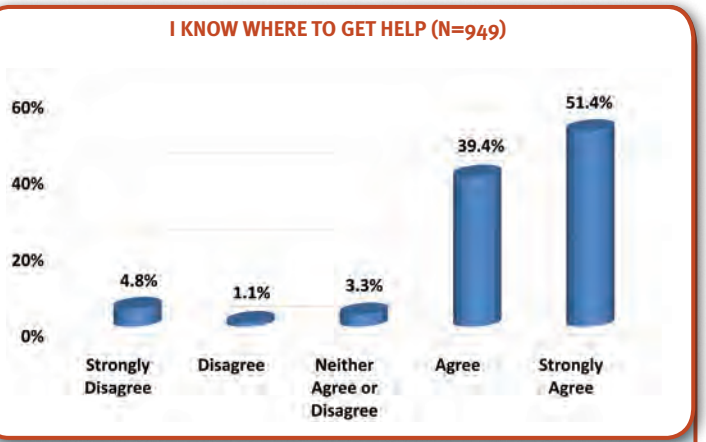
** Participants may have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



The majority of participants did not respond to program satisfaction questions. Of those who did respond, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 91% of the participants who responded to these questions were satisfied with the services received.

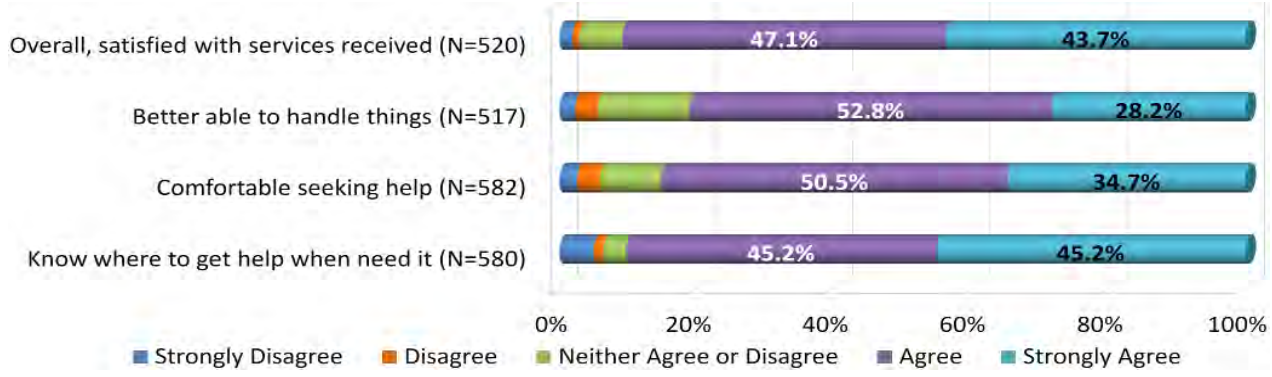
**Satisfaction data not available for all participants.*



The majority of participants responding to this question reported that they knew where to get help when they needed it. Approximately 6% did not agree with this statement.

SATISFACTION BY PROVIDER

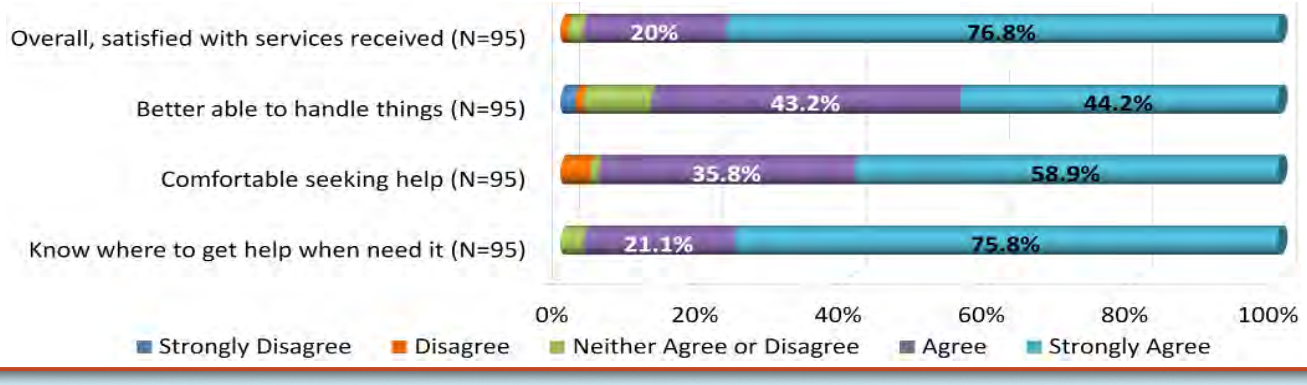
PROGRAM SATISFACTION: INDIAN HEALTH COUNSEL (N=591)*



Most participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the Indian Health Counsel programs. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 91% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*

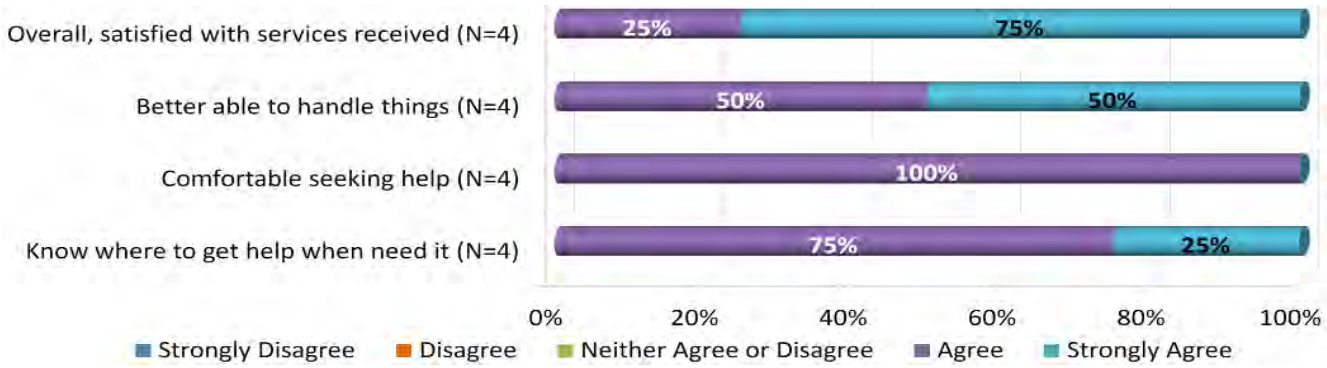
PROGRAM SATISFACTION: SOUTHERN INDIAN HEALTH COUNCIL (N=95)*



Most participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of Southern Indian Health Council's programs. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 97% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*

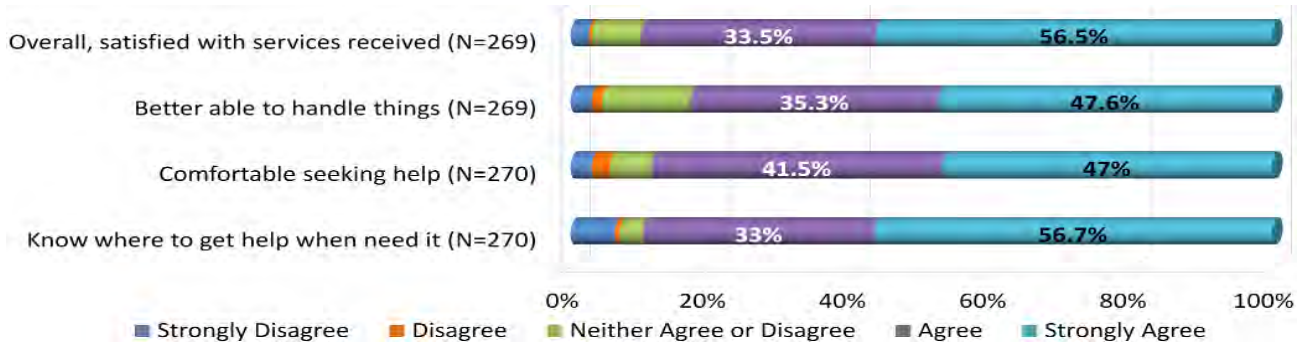
PROGRAM SATISFACTION: SYCUAN MEDICAL/DENTAL CENTER (N=4)*



Most participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the Sycuan Medical/Dental Center programs. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 100% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*

PROGRAM SATISFACTION: URBAN YOUTH CENTER (N=281)*



Most participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the Urban Youth Center programs. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 90% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*

The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

SCHOOL BASED PROGRAM-NORTH COUNTY (SA01NC): SCHOOL AGE SERVICES

PALOMAR FAMILY COUNSELING SERVICES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

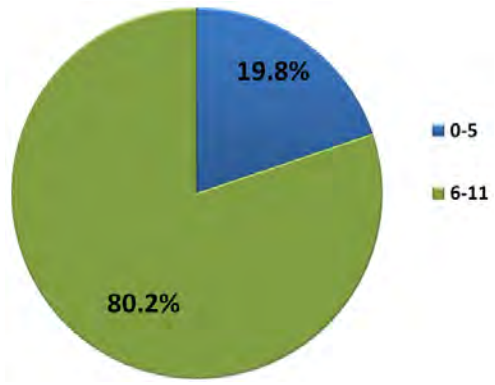
REGION: NORTH INLAND- DISTRICT 3

This program provides family-focused prevention and early intervention services for school-age children and their families in Escondido and Oceanside. The program has two components: a school-based component, known as School-Age Services (SAS), and a family-based component. This report focuses on the outcomes of the SAS component. SAS involves the implementation of the BEST Behavior program and the Incredible Years curriculum in preschool through third grades. The aim of the BEST program is to improve the school climate in order to promote positive behavior while the Incredible Years program helps students improve their social and emotional skills. Children are screened for signs of behavioral problems and receive prevention activities tailored to their specific needs.

CONTRACTOR:	Palomar Family Counseling Services		
CONTRACT START DATE:	11/2/2009	**DATA COLLECTION START DATE:**	1/1/2010
PROGRAM SERVICES START DATE:	11/2/2009	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	495	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	504

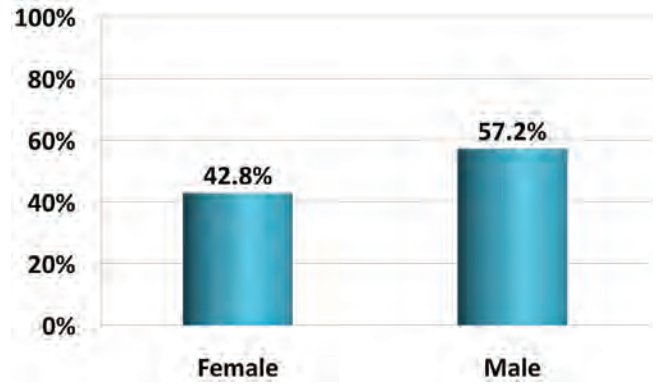
YOUTH DEMOGRAPHICS

AGE



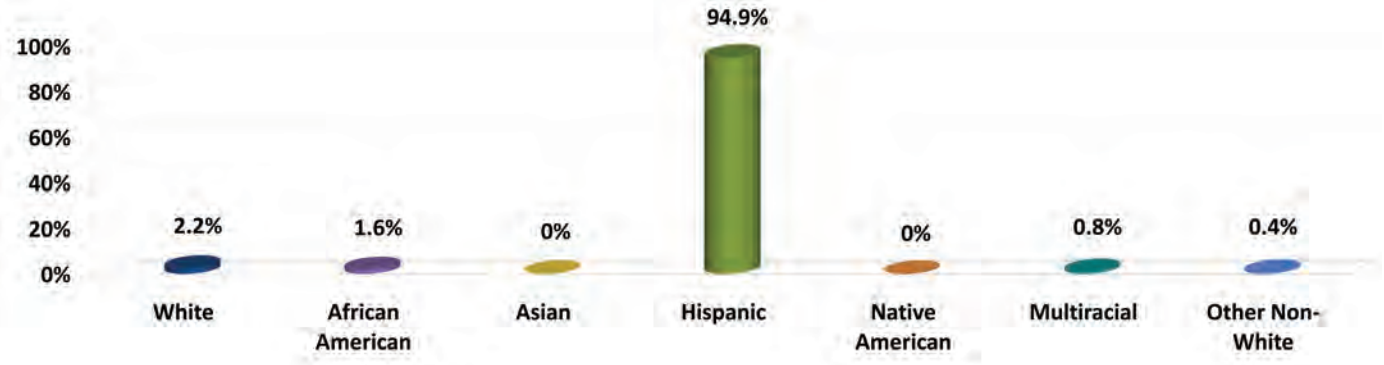
Of the children and youth who received School Age Services, roughly 80% were ages 6-11 while the remaining 20% were between the ages of 0-5. The age breakdown is representative of the youth population that is targeted by this intervention.

GENDER

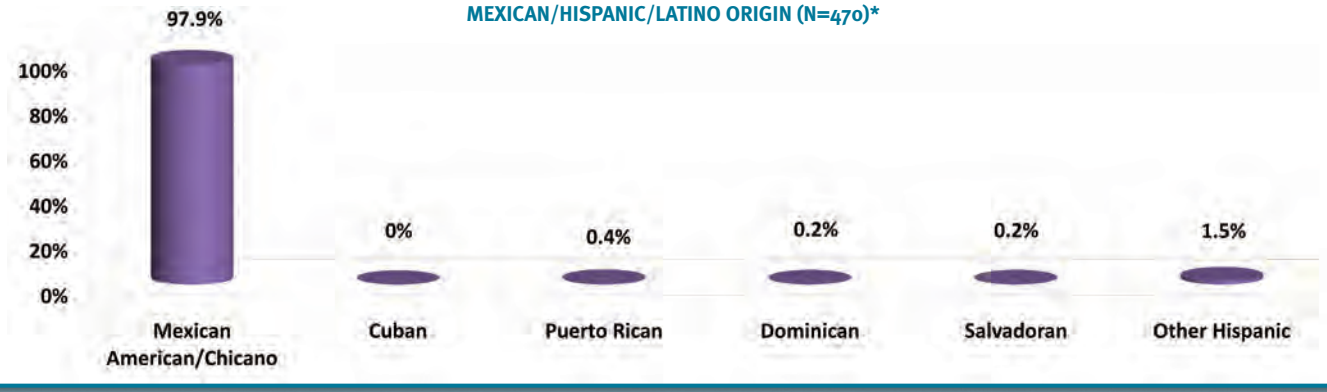


Fifty-seven percent of participants who received services were male while the remaining 43% of participants were female.

RACE/ETHNICITY



Approximately 95% of participants who received services were identified as Hispanic. Almost 4% of participants were identified as White or African American. The remaining racial/ethnic categories were not highly represented.



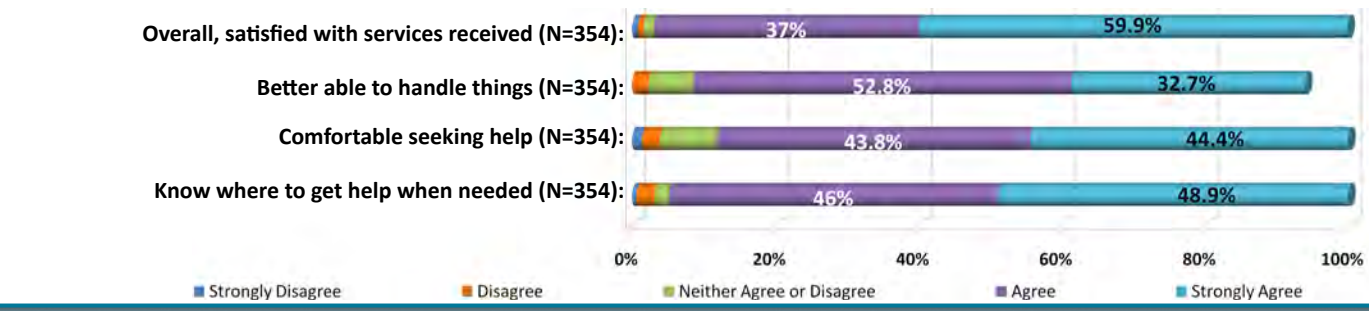
The majority of the Hispanic population served was identified as Mexican American/Chicano.

**Participants can be identified as more than one ethnicity so percentages may add up to more than 100%.*

MILITARY SERVICE

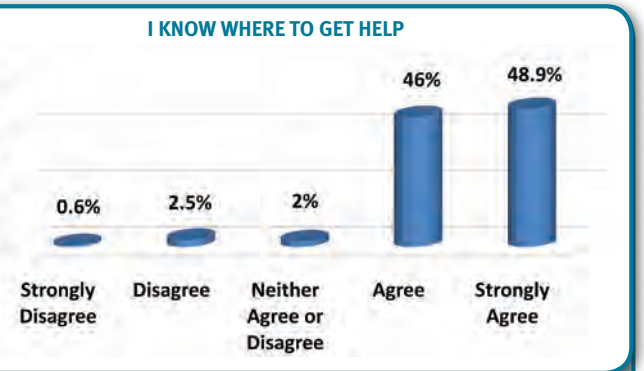
All 495 participants responded to this question. The majority (99%) reported that the child's caregiver had not served in the military. Of the 5 caregivers reported to have served in the military, two caregivers served in the Marine Corps, one served in the Air Force, one served in the Army, and one served in the Navy.

PROGRAM SATISFACTION



The majority of participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the program. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help as a result of participation in the program. Overall, 97% of the participants were satisfied with the services received.

** Satisfaction data not available for all participants.*



The majority of participants who responded to this question reported that they knew where to get help when they needed it. Only 3% did not agree with this statement.

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SCHOOL BASED PROGRAM-NORTH COUNTY (SA01NC): FAMILY COMMUNITY PARTNERSHIP

PALOMAR FAMILY COUNSELING SERVICES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

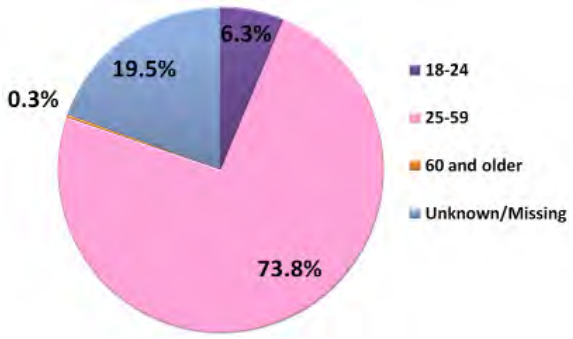
REGION: NORTH INLAND- DISTRICT 3

This program provides family-focused prevention and early intervention services for school-age children and their families in Escondido and Oceanside. The program has two components: a school-based component and a family-based component, known as the Family Community Partnership (FCP). This report focuses on the outcomes of the FCP component. FCP provides outreach services to families of the children served in the school-based program. These services are provided by bilingual community outreach specialists who inform parents about ways they can become involved in their child's school, and provide referrals to community resources. FCP also provides group activities for families. The aim of the program is to increase resiliency and protective factors for children by improving child/parent social and emotional skills and reducing parental stress.

CONTRACTOR:	Palomar Family Counseling Services		
CONTRACT START DATE:	11/2/2009	**DATA COLLECTION START DATE:**	1/1/2010
PROGRAM SERVICES START DATE:	11/2/2009	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	978	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	978

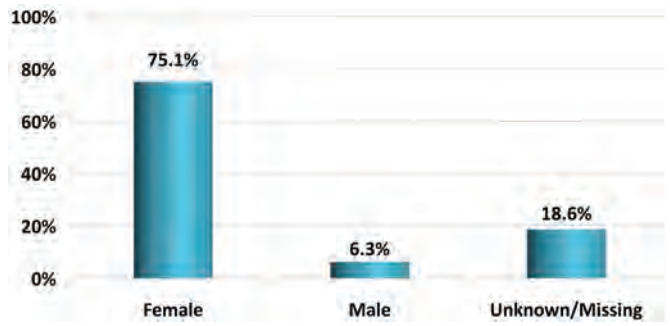
CAREGIVER DEMOGRAPHICS

AGE



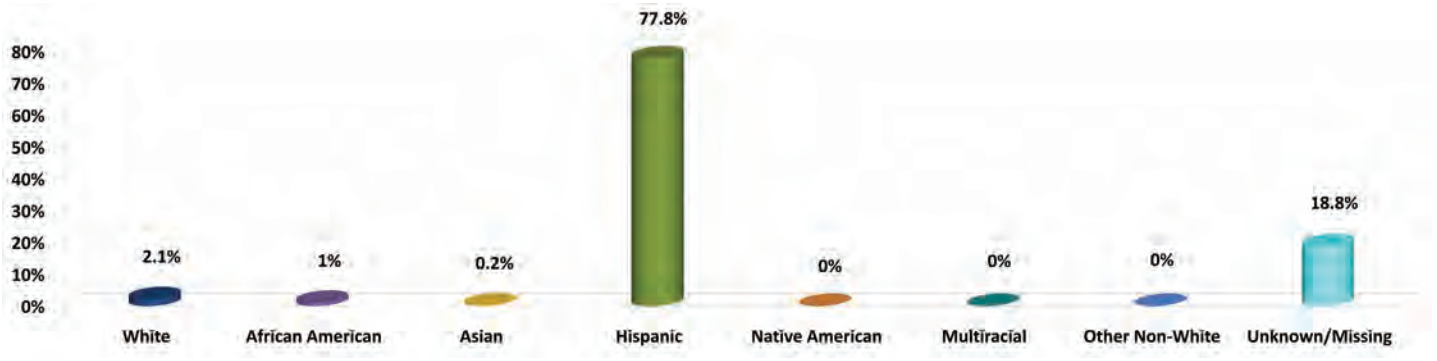
Nearly three-quarters of the caregivers who received Family Community Partnership Services were ages 25-59. Age was not reported for 20% of the participants.

GENDER

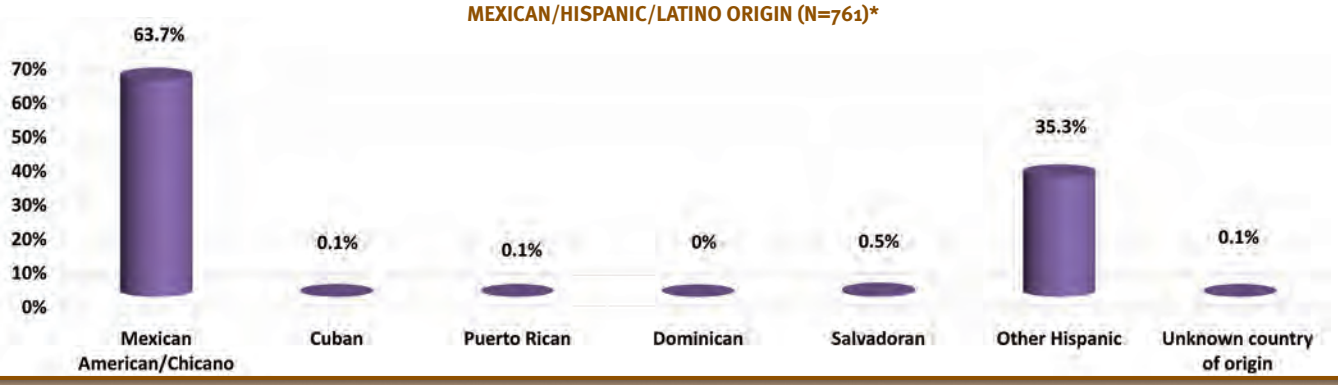


Over 75% of caregivers who received services were female; gender was not reported for 19% of the participants.

RACE/ETHNICITY



Approximately 78% of caregivers who received services identified their racial/ethnic background as Hispanic. Race/ethnicity was not reported for 19% of participants.



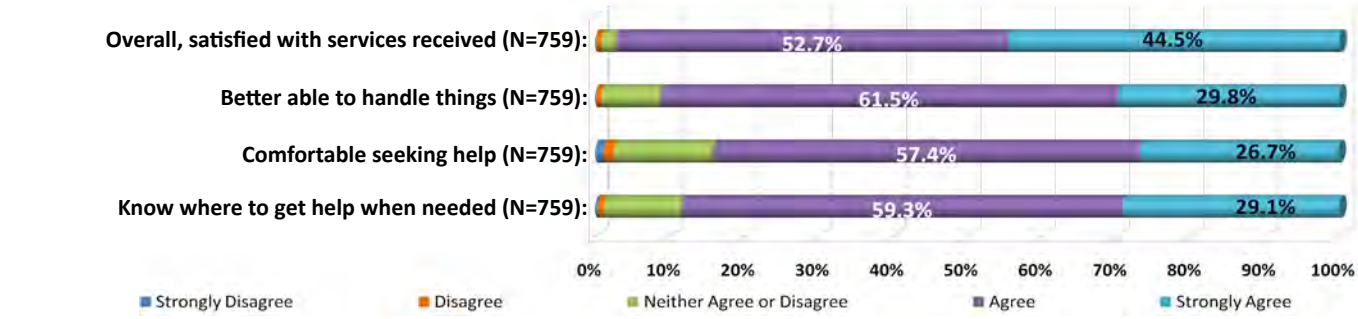
The majority of the Hispanic population served reported their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one ethnicity so percentages may add up to more than 100%.*

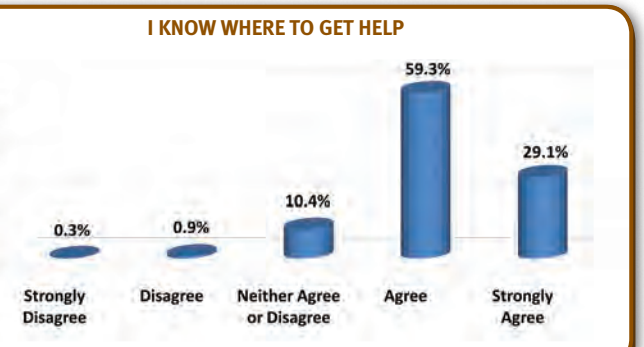
MILITARY DEMOGRAPHICS

Of 792 caregivers who responded to this question, the majority (99%) reported that they had not served in the military. Of the seven caregivers who said they had served in the military, four reported serving in the Army, one served in the Army Reserve, one served in the Marine Corps and one served in an unspecified branch.

PROGRAM SATISFACTION



The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the program. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help as a result of participation in the program. Overall, 97% of the caregivers were satisfied with the services received.



The majority of participants responding to this question reported that they knew where to get help when they needed it. However the percent of participants that stongly agreed with this statement was lower than the percent who marked strongly agree in other PEI programs.

The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

SCHOOL BASED PROGRAM-EAST COUNTY (SA01EC): FAMILY PROGRAMS

SAN DIEGO YOUTH SERVICES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

REGION: NORTH CENTRAL- DISTRICT 4

This program provides family-focused prevention and early intervention services for children who attend La Mesa Dale and Avondale elementary schools and their families. The program has two components: a school-based component and a family-based component. The family component includes parenting support groups, which use the Incredible Years curriculum, and culturally appropriate family-based activities that promote health and wellness. These interventions are designed to increase resiliency and protective factors for children by improving child/parent social and emotional skills and reducing parental stress. *This report focuses solely on the family component. For information about the school component, please see the annual report completed by Duerr Evaluation Resources.*

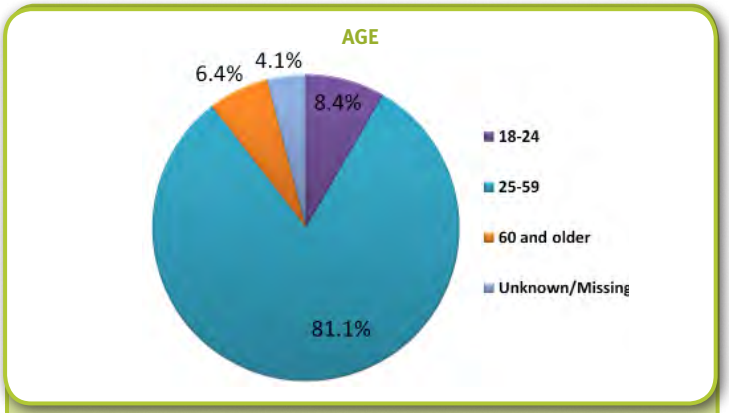
CONTRACTOR:	San Diego Youth Services		
CONTRACT START DATE:	7/1/2010	**DATA COLLECTION START DATE:**	1/10/2011
PROGRAM SERVICES START DATE:	9/27/2010	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	440 unduplicated	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	440

PROGRAM ATTENDANCE

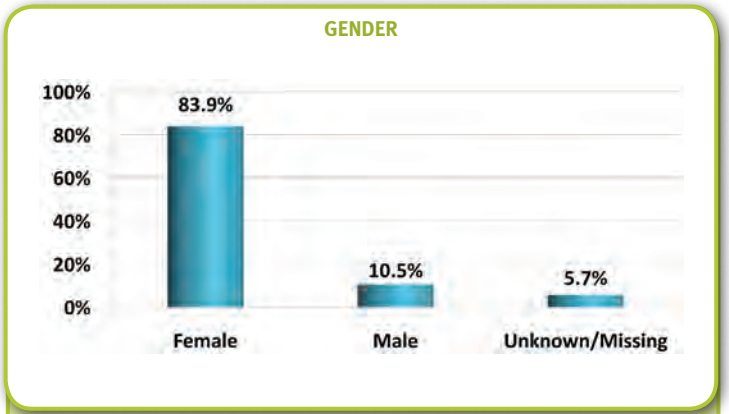
PROGRAM ATTENDANCE*	N	PERCENT
AVONDALE: PARENTING SUPPORT GROUP	54	12.3
AVONDALE: FAMILY PREVENTION EVENT	242	55
LA MESA: PARENTING SUPPORT GROUP	48	10.9
LA MESA: FAMILY PREVENTION EVENT	152	34.5
UNKNOWN LOCATION OR TYPE	27	6.1

**Numbers and percentages may add up to more than the total/ 100% because parents may have attended more than one location or type of activity.*

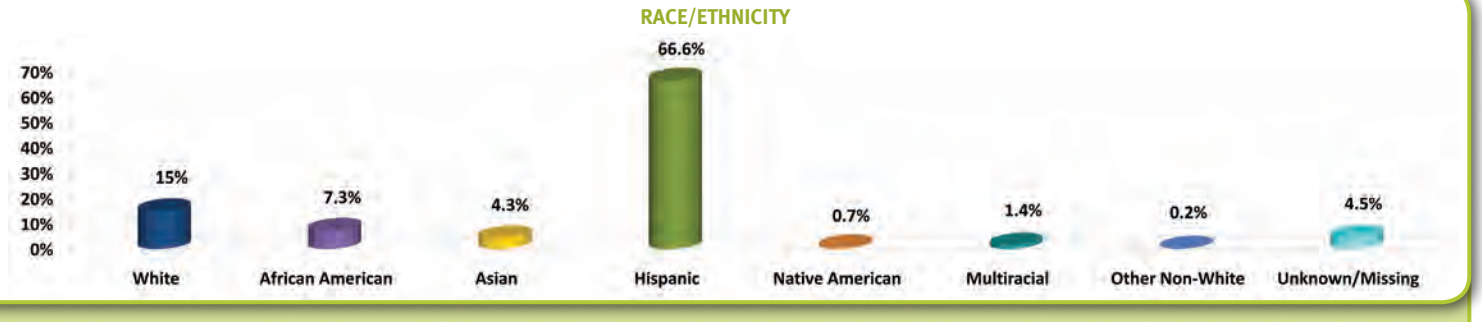
CAREGIVER DEMOGRAPHICS



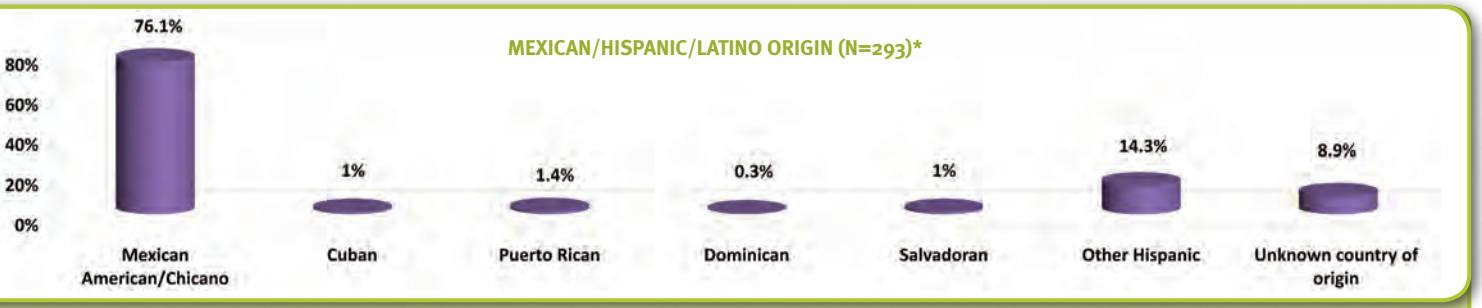
The majority of caregivers who participated in the family interventions (90%) were between the ages of 18-59. The age breakdown is representative of the adult population that is targeted by this part of the intervention.



Nearly 84% of caregivers who participated in the family interventions were female.



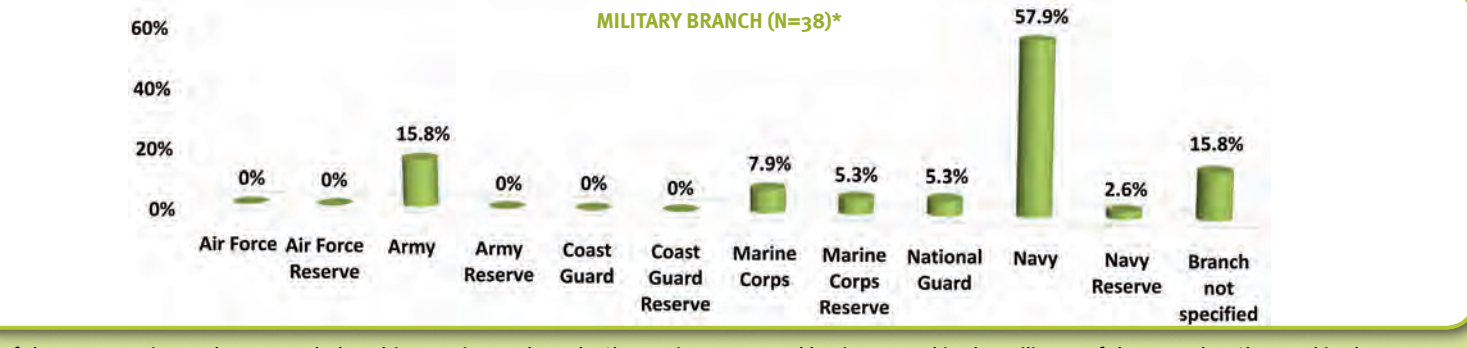
Two-thirds of caregivers who participated in the family interventions identified their racial/ethnic background as Hispanic.



The majority of the Hispanic population served reported their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

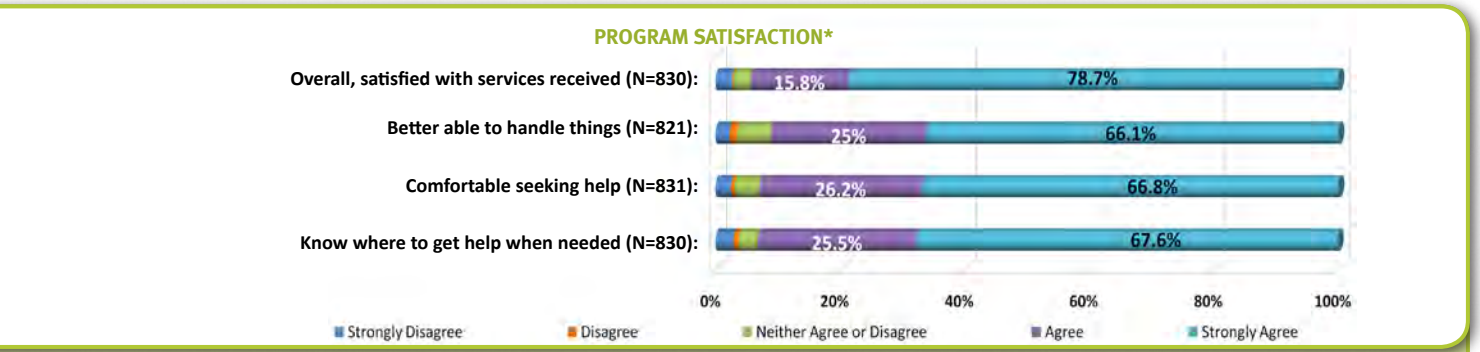
MILITARY SERVICE



Of the 404 caregivers who responded to this question, only 38 (9%) caregivers reported having served in the military. Of these, 22 (58%) served in the Navy, 6 (16%) served in the Army, and 3 (8%) served in the Marine Corps.

** Participants could have served in more than one military branch so percentages may add up to more than 100%.*

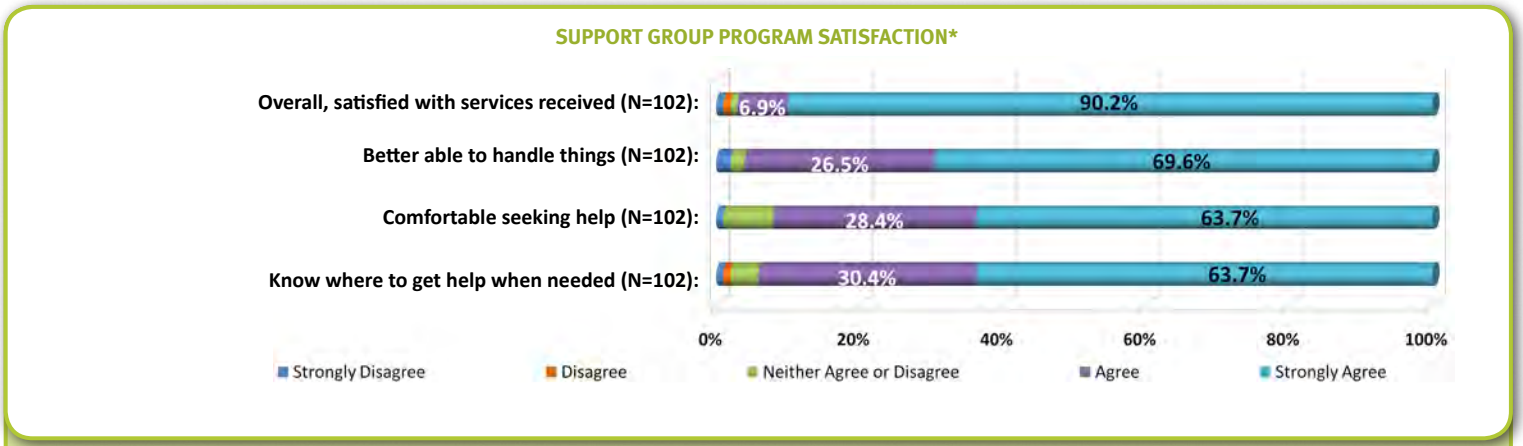
PROGRAM SATISFACTION



The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the program. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help as a result of participation in the program. Overall, 95% of the caregivers were satisfied with the services received.

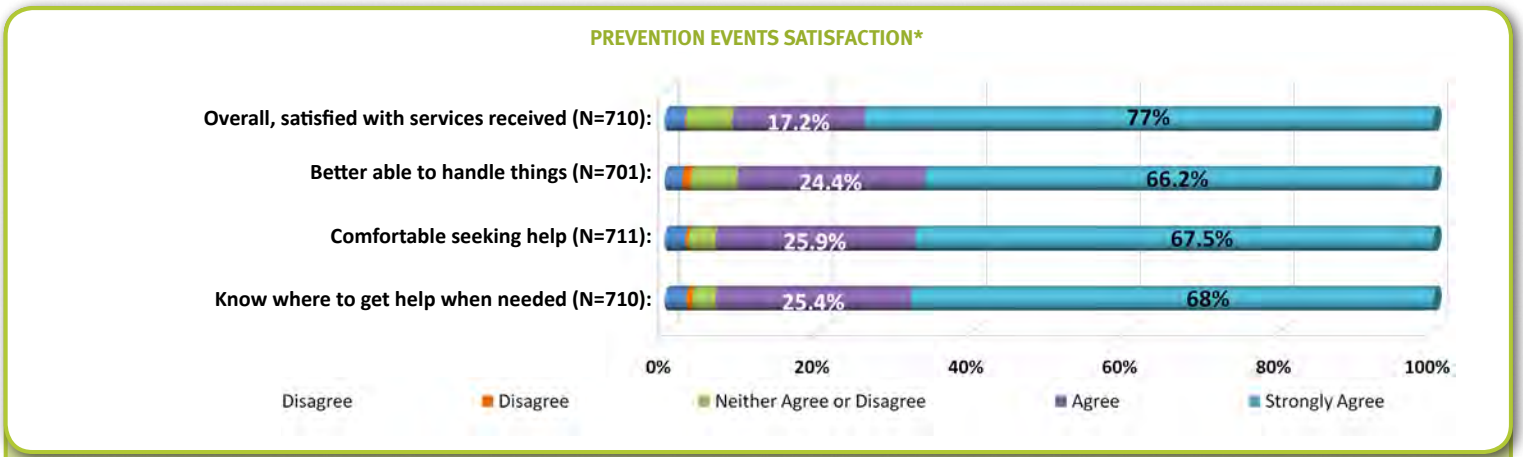
** Satisfaction data includes duplicated participants.*

The majority of caregivers responding to this question reported that they knew where to get help when they needed it. Only 4% did not agree with this statement.



The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the support groups. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help as a result of participation in the group program. Overall, 97% of the caregivers were satisfied with the services received in the support groups.

** Satisfaction data includes duplicated participants.*



The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the prevention events. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help as a result of participation in the events. Overall, 94% of the caregivers were satisfied with the services received.

** Satisfaction data includes duplicated participants.*

The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

YELLOW RIBBON SUICIDE PREVENTION (SA02): CAREGIVER OUTCOMES

MENTAL HEALTH RESOURCE CENTER

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

REGION: NORTH CENTRAL- DISTRICT 4

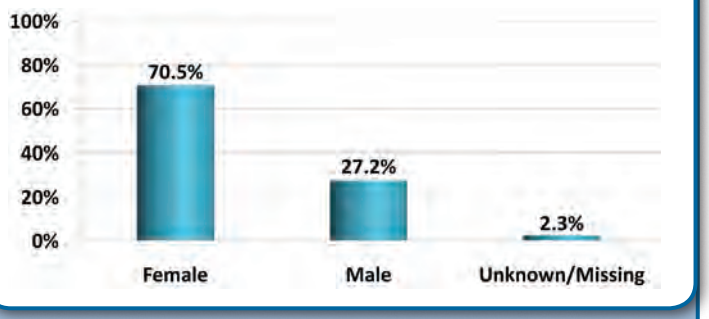
The School-Based Suicide Prevention program serves children, youth and transition-age youth (TAY) in school settings. This program provides presentations on the risk factors for suicide, how to respond to youth showing suicidal ideation, and where to go for help. The presentations, which are based on the Yellow Ribbon Suicide Prevention Program, are given to 7th, 9th, and 11th grade students, as well as to school staff, and parents. One of the goals of this program is to give presentations at every school in the San Diego Unified School District by the end of 2013.

CONTRACTOR:	Mental Health Resource Center		
CONTRACT START DATE:	November 2009	**DATA COLLECTION START DATE:**	October 2010
PROGRAM SERVICES START DATE:	August 2010	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	346*	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	387

**Data not available for all participants.*

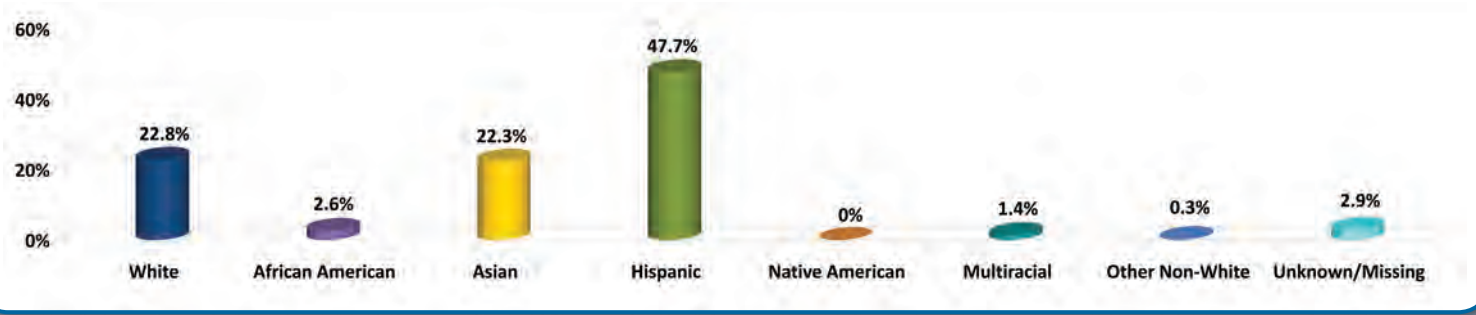
CAREGIVER DEMOGRAPHICS

GENDER

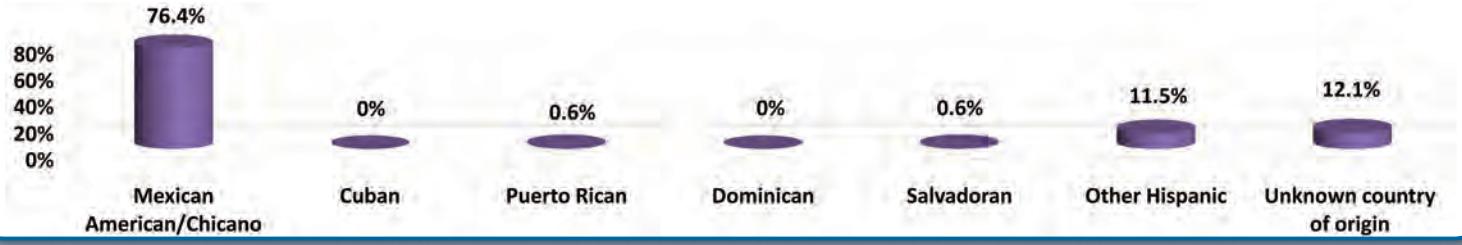


The majority of the caregivers in the sample were female.

RACE/ETHNICITY



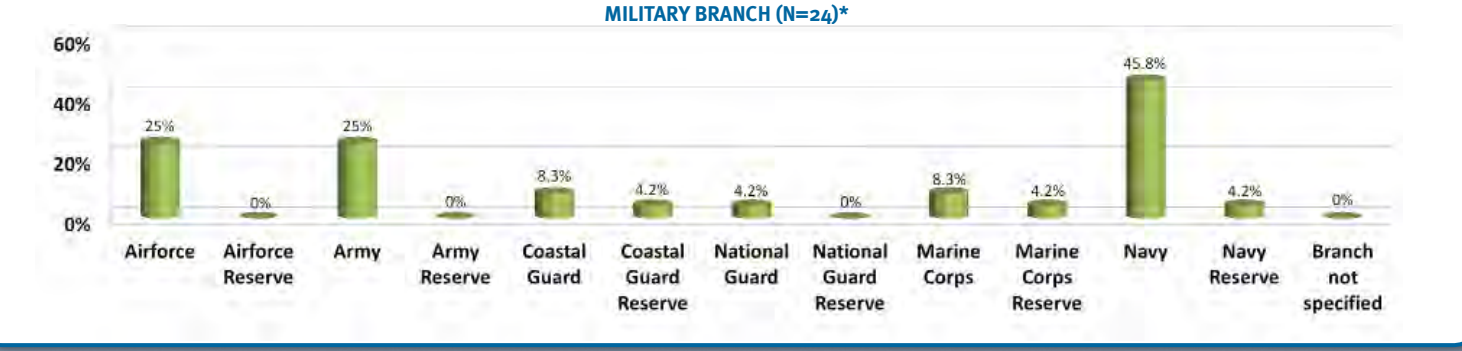
Almost half of the caregivers in the sample identified their ethnic background as Hispanic. Nearly one-quarter of the caregivers identified their ethnic background as White. A similar proportion of caregivers identified their ethnic background as Asian. The remaining racial/ethnic backgrounds were not highly represented.



The majority of the caregivers in the sample of Hispanic origin identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

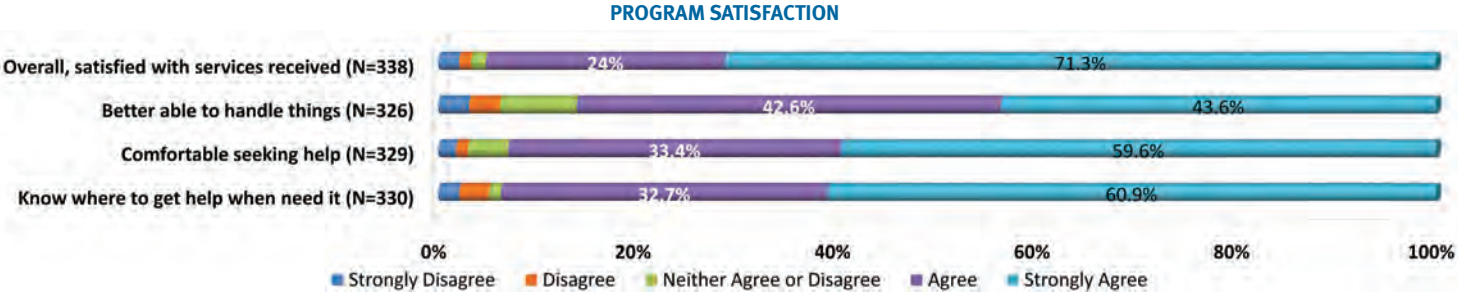
MILITARY SERVICE



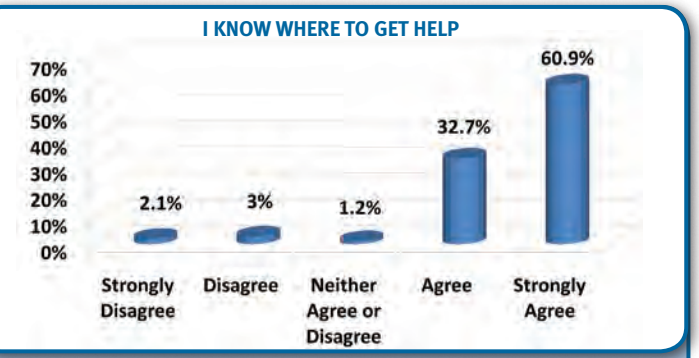
Of 319 caregivers that responded to this question, the majority (92%) reported that they had not served in the military. Of the 24 caregivers that reported they have served in the military, 11 (46%) served in the Navy. Six (25%) caregivers served in the Air Force and 6 (25%) served in the Army. The remaining military branches were not highly represented.

** Participants could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



Most caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the presentation. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 95% of the caregivers were satisfied with the services received.

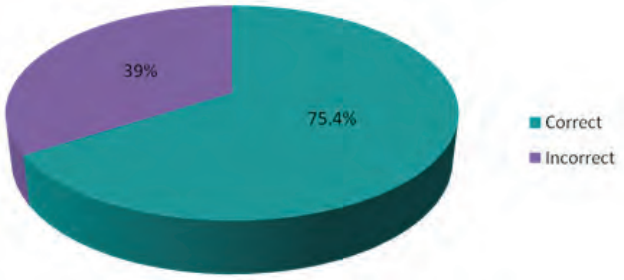


The majority of caregivers responding to this question reported that they knew where to get help when they needed it. Approximately 5% did not agree with this statement.

"I know where to get help when I need it."

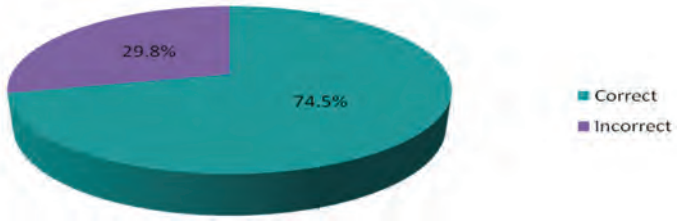
PROGRAM SPECIFIC OUTCOMES

PERCENT OF CAREGIVERS WHO CORRECTLY IDENTIFIED WARNING SIGNS OF SUICIDE.



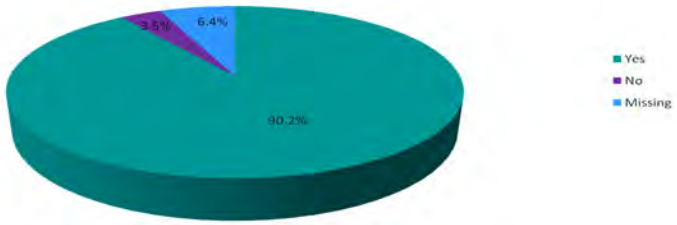
Approximately, 75% of caregivers correctly identified the warning signs of suicide after the presentation.

PERCENT OF CAREGIVERS WHO CORRECTLY IDENTIFIED THE PROTOCOL STEPS ON THE ASK 4 HELP CARD.



Following the presentation, approximately, 75% of caregivers correctly identified the protocol steps on the Ask 4 Help card.

IF A STUDENT CAME TO ME BECAUSE THEY WERE DEPRESSED OR HAVING SUICIDAL THOUGHTS, I WOULD KNOW WHO TO REFER THE STUDENT TO FOR HELP.



Following the presentation, 90% of the caregivers reported that if a student came to them because they were depressed or were having suicidal thoughts, they would know who to refer them to for help.

SUICIDE RISK REFERRALS	N
Referrals from FY2009-2010	130
Referrals from FY2010-2011	264
Referrals from schools that received presentations FY2010-2011	169 (64%)
Referrals that were made before the presentations	*103 out of 169*
Referrals that were made after the presentations	*66 out of 169*
Referrals from Schools that did not receive presentations FY2010-2011	95 (36%)
One of the goals of this PEI program is to increase the identification of students who are at risk for suicidal ideation and behavior. A greater number of students were identified in 2010-2011 (the year the PEI program began) than in 2009-2010.	

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YELLOW RIBBON SUICIDE PREVENTION (SA02): SCHOOL STAFF OUTCOMES

MENTAL HEALTH RESOURCE CENTER

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

REGION: NORTH CENTRAL- DISTRICT 4

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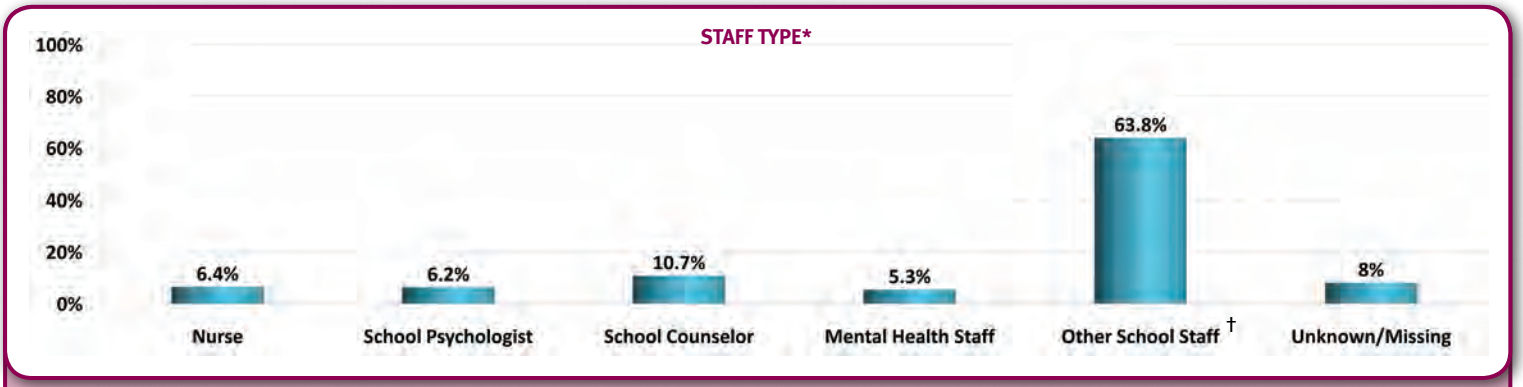
CONTRACTOR:	Mental Health Resource Center		
CONTRACT START DATE:	November 2009	**DATA COLLECTION START DATE:**	October 2010
PROGRAM SERVICES START DATE:	August 2010	**REPORT PERIOD:**	7/1/2010-6/30/2010
NUMBER OF PARTICIPANTS WITH DATA:	1953*	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	2381

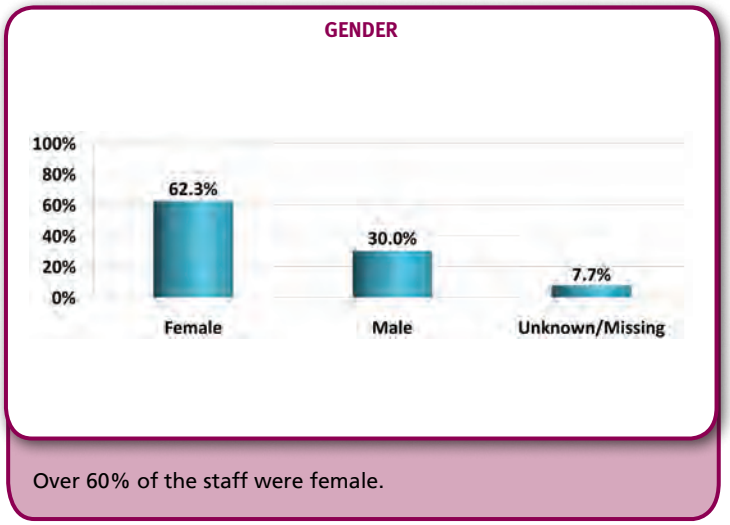
**Data not available for all participants.*

STAFF DEMOGRAPHICS

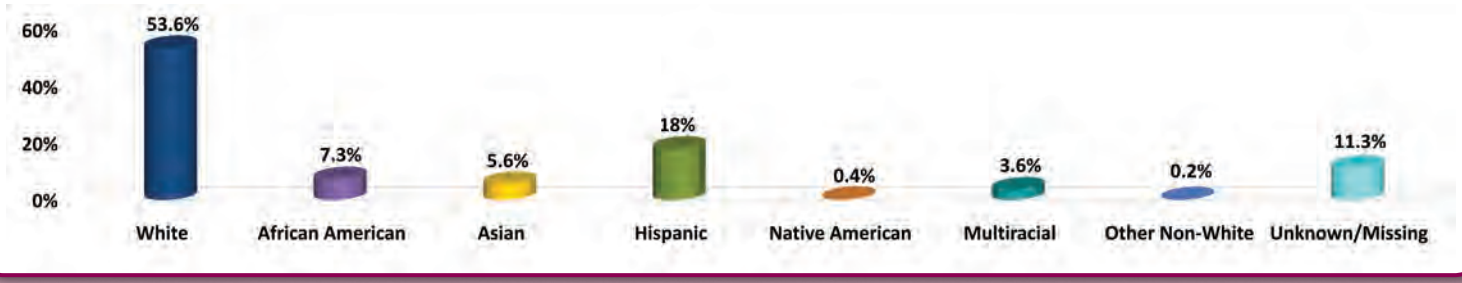


The majority (64%) of staff in the sample were not physical or mental health care providers.

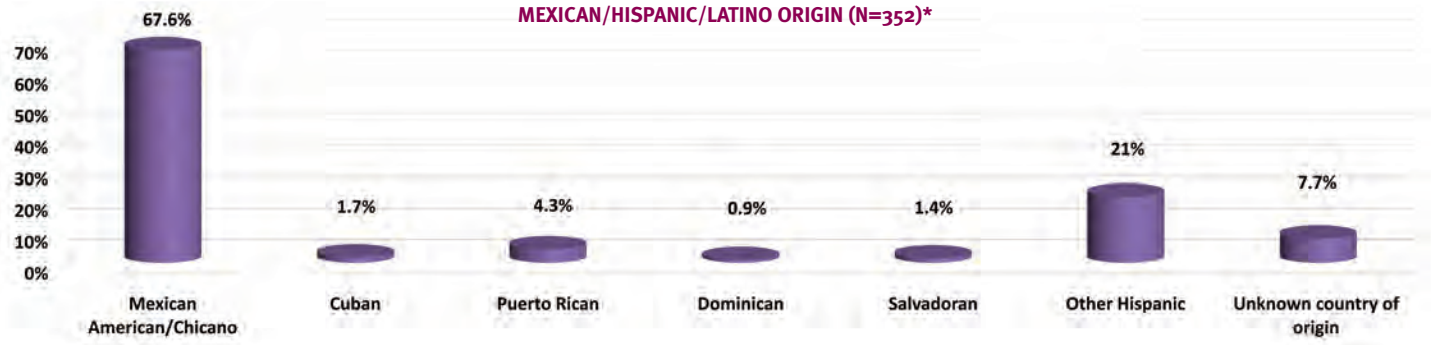
**Staff can self-identify as serving in more than one position so percentages may add up to more than 100%.*
† The majority of staff in this category are teachers.



Over 60% of the staff were female.



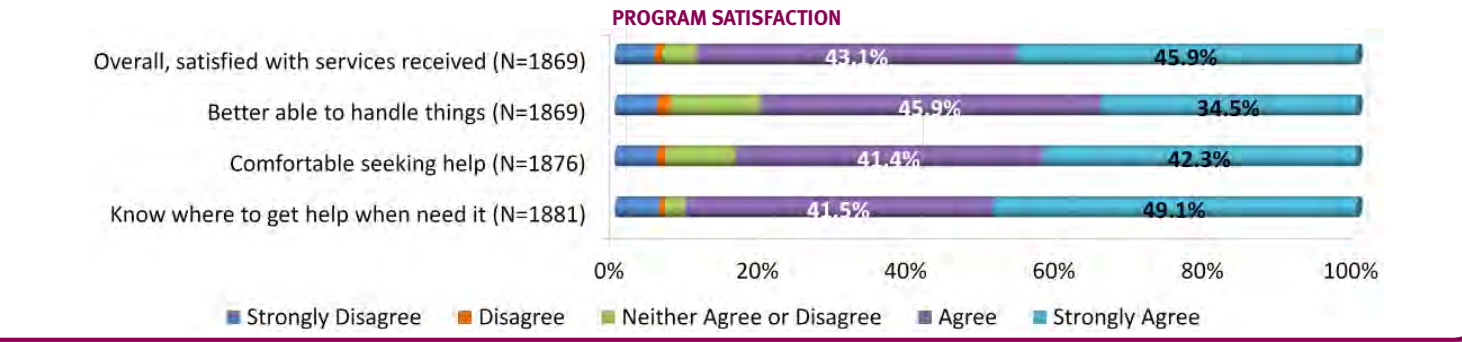
More than half of the staff identified their ethnic background as White, and 18% of staff identified their ethnic background as Hispanic. Approximately 11% of staff did not identify their racial/ethnic background.



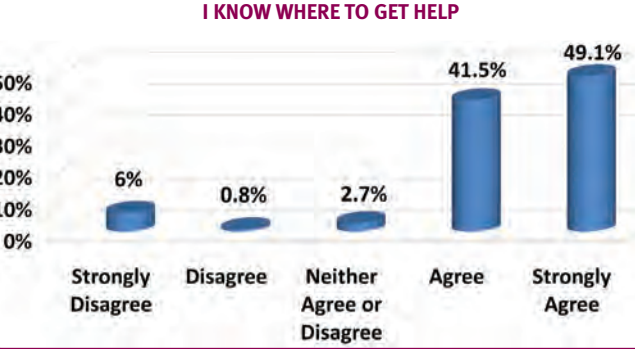
The majority of the Hispanic population in the sample identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



Most staff who responded to these questions agreed that they were better able to handle things and solve problems as a result of the presentation. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 89% of the staff were satisfied with the services received.

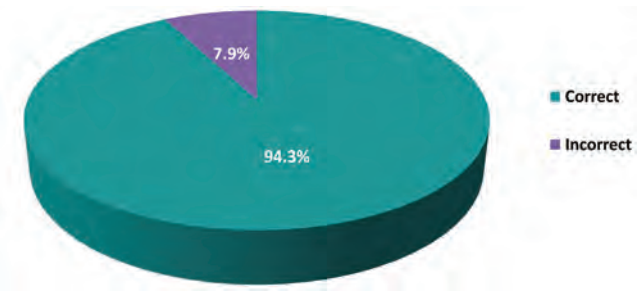


The majority of the staff responding to this question reported that they knew where to get help when they needed it. Approximately 7% did not agree with this statement.

"I know where to get help when I need it."

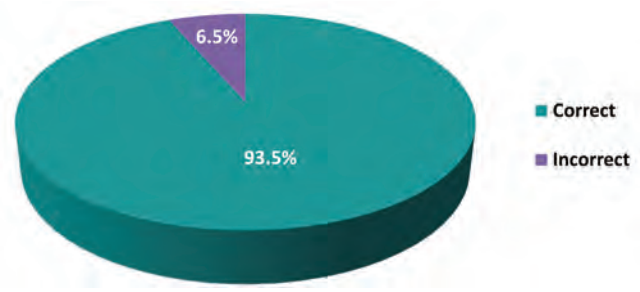
PROGRAM SPECIFIC QUESTIONS

PERCENT OF STAFF WHO CORRECTLY IDENTIFIED WARNING SIGNS OF SUICIDE.



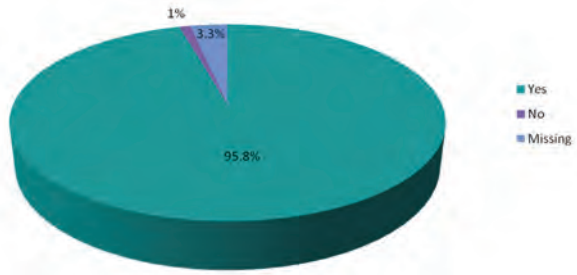
Following the presentation, approximately 94% of staff correctly identified the warning signs of suicidal ideation/behavior.

PERCENT OF STAFF WHO CORRECTLY IDENTIFIED THE PROTOCOL STEPS ON THE ASK 4 HELP CARD.



Following the presentation, approximately 94% of staff correctly identified the protocol steps on the Ask 4 Help card.

IF A STUDENT CAME TO ME BECAUSE THEY WERE DEPRESSED OR HAVING SUICIDAL THOUGHTS, I WOULD KNOW WHO TO REFER THE STUDENT TO FOR HELP.



Following the presentation, approximately 96% of the staff reported that if a student came to them because they were depressed or were having suicidal thoughts, they would know who to refer them to for help.

SUICIDE RISK REFERRALS	N
Referrals from FY2009-2010	130
Referrals from FY2010-2011	264
Referrals from schools that received presentations FY 2010-2011	169 (64%)
Referrals that were made before the presentations	*103 out of 169*
Referrals that were made after the presentations	*66 out of 169*
Referrals from schools that did not receive presentations	95 (36%)
One of the goals of this PEI program is to increase the identification of students who are at risk for suicidal ideation and behavior. A greater number of students were identified in 2010-2011 (the year the PEI program began) than in 2009-2010.	

The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

YELLOW RIBBON SUICIDE PREVENTION (SA02): STUDENT OUTCOMES

MENTAL HEALTH RESOURCE CENTER

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

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CASRC child and adolescent services research center

REGION: NORTH CENTRAL- DISTRICT 4

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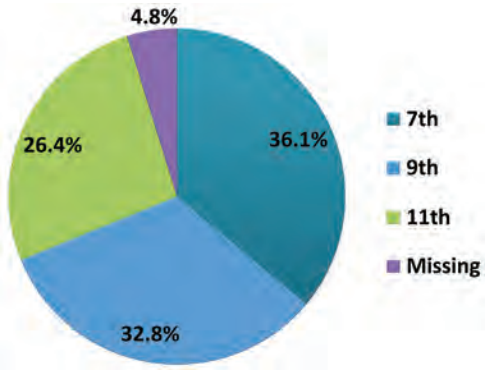
CONTRACTOR:	Mental Health Resource Center		
CONTRACT START DATE:	November 2009	**DATA COLLECTION START DATE:**	October 2010
PROGRAM SERVICES START DATE:	August 2010	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	3470	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	8944

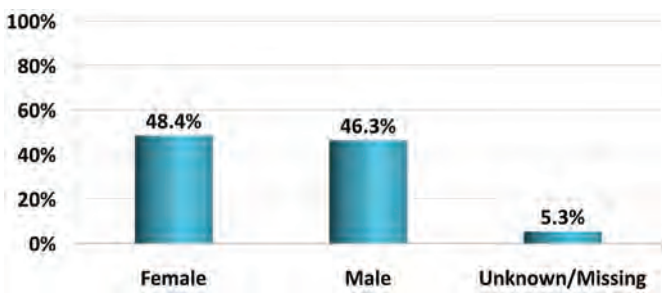
STUDENT DEMOGRAPHICS

SCHOOL GRADE



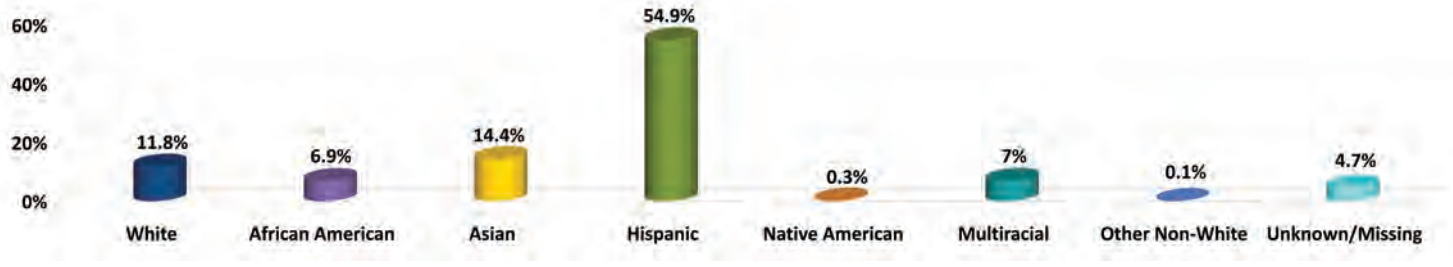
The sample population used for the analysis contained slightly more 7th graders (36%) than 9th (33%) and 11th graders (26%).

GENDER

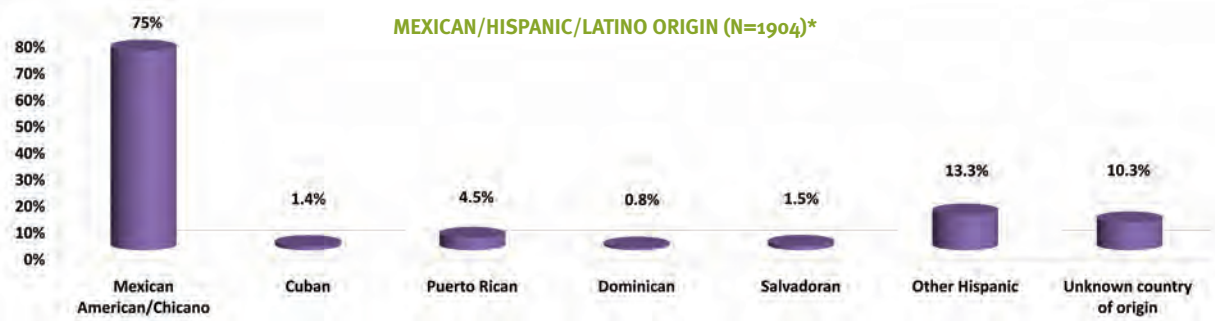


The sample population was comprised of slightly more females than males.

RACE/ETHNICITY



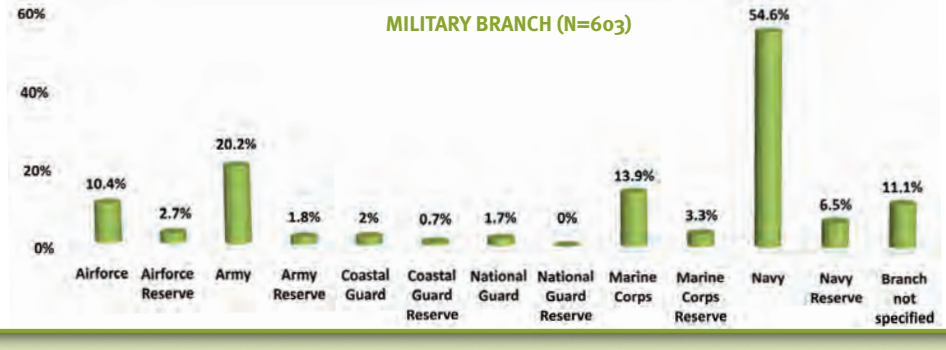
More than half of the students in the sample identified their ethnic background as Hispanic. Almost 15% of students identified their ethnic background as Asian.



The majority of the Hispanic population in the sample identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

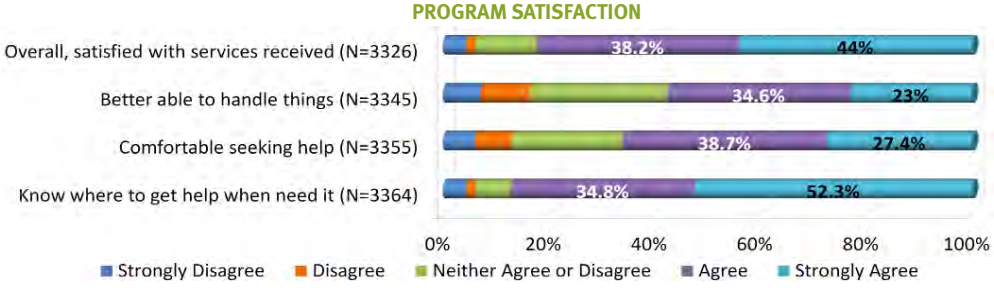
MILITARY SERVICE



Of the 2674 students who responded to this question, 77% reported that their caregivers had not served in the military. Of the 603 students who reported that their caregiver has served in the military, 329 (55%) reported their caregivers have served in the Navy and 122 (20%) reported that their caregiver served in the Army. Additionally, 84 (14%) students reported their caregivers served in the Marine Corps and 63 (10%) students reported their caregiver served in the Air Force. The remaining military branches were not highly represented.

** Participants could have served in more than one military branch so percentages may add up to more than 100%·*

PROGRAM SATISFACTION



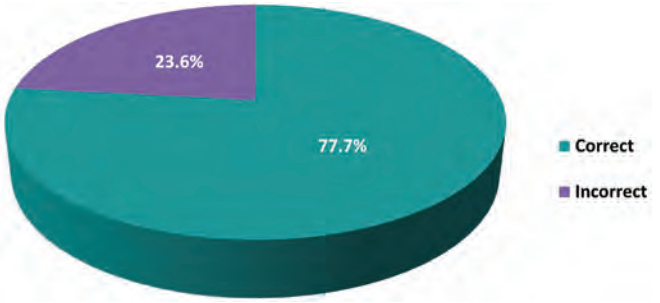
Most students in the sample who responded to these questions agreed that they were better able to handle things and solve problems as a result of the presentation. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 82% of the students in the sample were satisfied with the services received.

The majority of students in the sample responding to this question reported that they knew where to get help when they needed it. Approximately 6% did not agree with this statement.

"I **know** *where* **to** *get help* when **I need it.**"

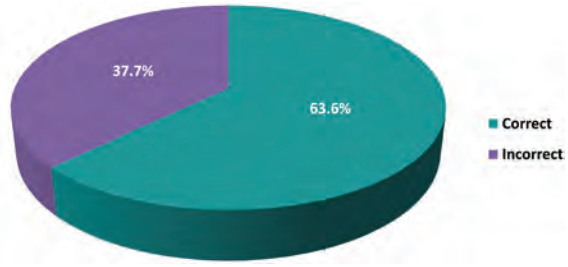
PROGRAM SPECIFIC OUTCOMES

PERCENT OF STUDENTS WHO CORRECTLY IDENTIFIED WARNING SIGNS OF SUICIDE.



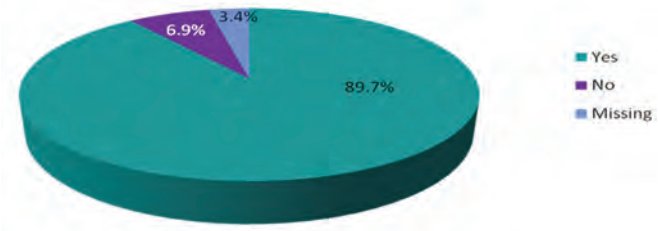
Following the presentation, approximately 78% of students in the sample correctly identified the warning signs of suicidal ideation/ behavior.

PERCENT OF STUDENTS WHO CORRECTLY IDENTIFIED THE STEPS TO TAKE IF A FRIEND SAYS HE/SHE IS CONSIDERING SUICIDE.



Following the presentation, approximately 64% of students in the sample correctly identified the steps to take if a friend is considering suicide.

IF I FELT DEPRESSED OR WAS HAVING SUICIDAL THOUGHTS, I KNOW WHO TO GO TO FOR HELP:



Following the presentation, roughly 88% of students in the sample reported that if they were depressed or were having suicidal thoughts, they would know who to go to for help.

SUICIDE RISK REFERRALS	N
Referrals from FY2009-2010	130
Referrals from FY2010-2011	264
Referrals from schools that received presentations FY2010-2011	169 (64%)
Referrals that were made before the presentations	*103 out of 169*
Referrals that were made after the presentations	*66 out of 169*
Referrals from schools that did not receive presentations FY2010-2011	95 (36%)

One of the goals of this PEI program is to increase the identification of students who are at risk for suicidal ideation and behavior. A greater number of students were identified in 2010-2011 (the year the PEI program began) than in 2009-2010.

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APPENDIX C – FISCAL YEAR 2012/13 BUDGET SUMMARY

This section includes the following:

1. Fiscal Year 2012/13 Budget Summary
2. Proposed Enhancements for Community Services and Supports Programs
3. Proposed Enhancements for Prevention and Early Intervention Programs

DRAFT

FY 2012/13
MHSA FUNDING SUMMARY

County: San Diego **Date:** 5/3/2012

	MHSA Funding					
	CSS	**WET**	**CFTN**	**PEI**	**INN**	**Local Prudent Reserve**
A. Estimated FY 2012/13 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$24,798,827	$10,747,484	$24,794,255	$22,025,167	$7,670,851	
2. Estimated New FY 2012/13 Funding	$65,662,363			$16,765,616	$4,230,884	
3. Transfer in FY 2012/13[a/]	($140,000)	$140,000	$0			
4. Access Local Pruduent Reserve in FY 2012/13						
5. Estimated Available Funding for FY 2012/13	$90,321,190	$10,887,484	$24,794,255	$38,790,783	$11,901,735	
B. Estimated FY 2012/13 Expenditures	$89,791,541	$3,781,961	$16,671,210	$30,294,895	$10,824,051	
C. Estimated FY 2012/13 Contingency Funding	$529,649	$7,105,523	$8,123,045	$8,495,888	$1,077,684	

[a/]Per Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2012	$42,193,120
2. Contributions to the Local Prudent Reserve in FY12/13	$0
3. Distributions from Local Prudent Reserve in FY12/13	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2013	$42,193,120

				FY 12/13 Required MHSA Funding	Estimated MHSA Funds by Service Category				Estimated MHSA Funds by Age Group			
	No.	Name	# addtl clients		Full Service Partnerships (FSP)	System Development	Outreach and Engagement	MHSA Housing Program	Children, Youth, and Families	Transition Age Youth	Adult	Older Adult
CY-FSP	CY-3	Cultural/Language Specific Outpatient										
	CY-5.3	Homeless and Runaways										
	CY-7	Wraparound Services										
	CY-10	Case Management	500	$600,000	$600,000				$600,000			
				$600,000	$600,000	$0	$0	$0	$600,000	$0	$0	$0
CY-SD	CY-2.1	Family and Youth Information/Education Program										
	CY-2.2	Family/Youth Peer Support Services	100	$250,000		$250,000			$250,000			
	CY-4.2	Mobile Psychiatric Emergency Response/Children's Walk-In Assessment Center										
	CY-5.1	Medication Support For Dependents and Wards										
	CY-6	Early Childhood Mental Health Services										
	CY-8	Child Welfare Supportive Services and Treatment	870	$1,355,000		$1,355,000			$1,355,000			
	CY-9	Juvenile Justice/Probation Services										
				$1,605,000	$0	$1,605,000	$0	$0	$1,605,000	$0	$0	$0
CY-OE	CY-1	School and Home Based Services										
	CY-5.2	Outpatient Court Schools and Outreach										
				$0	$0	$0	$0	$0	$0	$0	$0	$0
TAOA-FSP	A-1	Integrated Services and Supported Housing		$10,000	$10,000					$1,000	$9,000	
	A-2	Justice Integrated Srvs. and Supported Housing										
	TAY-1	Integrated Services and Supported Housing										
	TA-1	Intensive Case Management										
	TA-2	Dual Diagnosis Residential Treatment Program										
	TAOAFSP		150	$2,100,000	$2,100,000					$ 490,000	$1,470,000	$ 140,000
	OA-1	High Utilizer Integrated Services and Supported Housing										
	OA-4	Strength-Based Care Management Plus										
	TAOA-3	Housing Trust Fund										

				FY 12/13 Required MHSA Funding	Estimated MHSA Funds by Service Category				Estimated MHSA Funds by Age Group			
	No.	Name	# addtl clients		Full Service Partnerships (FSP)	System Development	Outreach and Engagement	MHSA Housing Program	Children, Youth, and Families	Transition Age Youth	Adult	Older Adult
	TAOA-5	Mental Health Court Calendar										
				$2,110,000	$2,110,000	$0	$0	$0	$0	$491,000	$1,479,000	$140,000
TAOA-SD	A-3	Client-Operated Peer Support Services										
	A-4	Family Education Services										
	A-5	Clubhouse Enhance and Expand with Employment										
	AOA-1	Enhanced Outpatient Mental Health Services										
	A-6	Supported Employment Services										
	A-10	Patient Advocacy for Board and Care Facilities										
	OA-2	Mobile Outreach at Home and Community										
	TAY-2	Clubhouse and Peer Support Services										
	TAOASD	New funding	620	$1,577,807		$1,577,807				$ 644,497	$ 818,996	$ 114,314
	TAOASD	SUSTAIN FROM ENH #8	572	$719,000		$719,000				$ 141,085	$ 489,918	$ 87,997
	TAY-4	Enhanced Outpatient Mental Health Services										
	TAOA-1	Legal Services										
	TAOA-2	North County Walk-in Assessment Center										
	TAOA-4	Peer Telephone Support										
				$2,296,807	$0	$2,296,807	$0	$0	$0	$785,582	$1,308,914	$202,311
ALL-SD	ALL-4	Interpreter Services										
	ALL-5	Psychiatric Emergency Response Team		$50,000		$50,000				$16,666	$16,668	$16,666
	ALL-7	Chaldean Outpatient Services	58	$155,000		$155,000			$75,000	$12,000	$60,000	$8,000
				$205,000	$0	$205,000	$0	$0	$75,000	$28,666	$76,668	$24,666
ALL-OE	ALL-1	Services for Deaf and Hard of Hearing										
	ALL-2	Services for Victims of Trauma and Torture	19	$50,000			$50,000			$7,500	$37,500	$5,000
	ALL-6	Mental Health & Primary Care										
				$50,000	$0	$0	$50,000	$0	$0	$7,500	$37,500	$5,000
	Total		2,889	**$6,866,807**	$2,710,000	$4,106,807	$50,000	$0	$2,280,000	$1,312,748	$2,902,082	$371,977
									33.20%	19.12%	42.26%	5.42%

PEI Work Plans		# addtl clients	FY 12/13 Proposed Additional Funding	Estimated MHSA Funds by Age Group			
No.	Name			Children, Youth, and Families	Transition Age Youth	Adult	Older Adult
PS01	Outreach and Education; Media Campaigns & Targeted Populations						
PS01C	*Breaking Down Barriers* *Mental Health 101* *AA Outreach* *NAMI / In Our Own Voice* *Deaf Community Prevention* *NAMI/ Friends in the Lobby*	10,025	$1,258,839	$150,000	$170,960	$786,995	$150,884
VF01	Veterans and Families Outreach and Education Program						
DV01	South Region Point of Engagement	300	$100,000	$100,000			
DV02	South Region and Polinsky Children's Center Trauma Exposed Services						
DV03	Central Region Community Violence Services	100	$120,000	$120,000			
RC01	Rural Integrated Behavioral Health and Primary Care Services		$150,000	$150,000			
NA01	Dream Weaver						
EC01	Positive Parenting Program (Triple P)						
SA01	School-Based Program	1,500	$300,000	$300,000			
SA02	School-Based Suicide Prevention						
FB01	Kick Start	79	$475,000	$325,000	$150,000		
CO01	Bridge to Recovery						
CO02	Screening, Community Based Alcohol and Drug Services (ADS) Programs	2,755	$1,140,000	$420,000	$353,626	$335,518	$30,856
OA01	Elder Multicultural Access and Support Services (EMASS)	75	$125,000				$125,000
OA02	Positive Solutions	50	$125,000				$125,000
OA03	Aging in Place		$100,000				$100,000
OA04	REACHing-Out	100	$80,000				$80,000
OA05	Salud	110	$150,000				$150,000
		15,194	$4,223,839	$1,665,000	$674,586	$1,122,513	$761,740
				39.4%	16.0%	26.6%	18.0%

APPENDIX D – COUNTY CERTIFICATION

DRAFT

COUNTY CERTIFICATION

Exhibit A

County: _____

County Mental Health Director	Project Lead
Name: Telephone Number: E-mail:	Name: Telephone Number: E-mail:
Mailing Address:	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations, laws and statutes for this annual update/update. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

This annual update has been developed with the participation of stakeholders, in accordance with Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft FY 2012/13 annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate.

A.B. 100 (Committee on Budget – 2011) significantly amended the Mental Health Services Act to streamline the approval processes of programs developed. Among other changes, A.B. 100 deleted the requirement that the three year plan and updates be approved by the Department of Mental Health after review and comment by the Mental Health Services Oversight and Accountability Commission. In light of this change, the goal of this update is to provide stakeholders with meaningful information about the status of local programs and expenditures.

The costs of any Capital Facilities renovation projects in this annual update are reasonable and consistent with what a prudent buyer would incur.

The information provided for each work plan is true and correct.

All documents in the attached FY 2012/13 annual update/update are true and correct.

_____ _____

Mental Health Director/Designee (PRINT) Signature Date

County:_____

Date:_____